Why the Myth of Mental Illness Lives On

51–65 minutes

"The opinion that mental illness does not exist has been advanced by, among others, psychiatrist Thomas Szasz, sociologists Thomas Scheff and Erving Goffman, and psychologist Theodore Sarbin" (Judi Chamberlin, *Own Our Own*, National Empowerment Center 1977, p. 8). In his testimony before the Mental Health Committee of the New York State Assembly (state legislature) on May 18, 2001, neurologist John Friedberg, M.D., said this:

> I do not believe in mental illness. ... Psychiatric drugs and electroshock inflict real injury in the name of treating fictive maladies. ... My opinions are based on my years of experience with patients and review of records from all over the country as an expert witness in electroshock malpractice cases.

In 2011, Steve Balt, M.D., a psychiatrist at the UCLA-Kern Medical Center in Bakersfield, California, acknowledged "some argue convincingly that mental illness is itself a false concept" ("Is the Criticism of DSM-5 Misguided?", psychiatrictimes.com & thoughtbroadcast.com), citing an article by psychiatry professor Thomas Szasz. Dr. Szasz published his book *The Myth of Mental Illness* in 1961, which now in 2014 is fifty-three years ago. If mental illness is a myth, why do people still believe in mental illness?

One reason is the effects of repetition over time. The more often one hears a myth stated, the harder it is to bring oneself to use one's own powers of perception and reason to examine and question it. Almost everything we read in newspapers and magazines, and almost everything we see on television or hear on radio, and much of what we read on the Internet, discusses "mental illness" as if it were as real and valid a concept as heart disease or cancer. We tend to believe what those around us believe, and eventually "most of our stored misinformation is virtually [metaphorically] cast in concrete" (Donald G. Smith, *How to Cure Yourself of Positive Thinking*, E. A. Seemann Publishing, Inc., Miami, 1976, p. 73).

Another reason the myth of mental illness and other widespread myths persist is the risk to anyone who questions what almost everyone believes. Dare one be the first to declare the emperor has no clothes? People who clearly understand the mythical nature of a widespread belief risk the disapproval of others, or worse, if they speak the truth about these myths. Historians have said those questioning the concept of witchcraft in the 1690s when the Salem witch trials took place risked being accused of being witches themselves. According to Peter Charles Hoffer, research professor of history at the University of Georgia, in his book *The Salem Witchcraft Trials—A Legal History*, "In the 1600s, popular or 'vernacular' belief in witches was repeated in the writings of the most learned men. ... In the late sixteenth century, many educated men assumed that there was a spirit (invisible) world, and that the Devil and His witches could move freely through it. ... Everyone believed in witches ... no lawyers stepped forward during the [witch] trials to help the accused", but if they had, the people making such

accusations "would probably have accused the lawyers of witchcraft before long" (University Press of Kansas 1997, pp. 4, 78, 87, 89, 90).

Just as lawyers speaking on behalf of defendants in the Salem, Massachusetts witchcraft trials of the 1690s would have been in danger of being accused of witchcraft themselves, as a lawyer representing or speaking in defense of people accused of mental illness today, a reaction I sometimes get is people accusing *me* of being crazy. As psychiatry professor Thomas Szasz says in his book *Suicide Prohibition—The Shame of Medicine*, "The individual who assumes the task of setting such dislocations aright runs the risk of being destroyed in the process" (Syracuse University Press 2011, p. 105).

A related reason for the persistence of the concept of mental illness is support by supposed experts —psychiatrists and psychologists—who make money and acquire professional prestige with the use of the concept. Their status as experts would be lost and their incomes would drop dramatically if the falseness of the concept of mental illness were widely and generally acknowledged. As Judi Chamberlin wrote in her book about psychiatry, "Leaving the determination of whether mental illness exists strictly to the psychiatrists is like leaving the determination of the validity of astrology in the hands of professional astrologers" (*Own Our Own*, p. 9). Support for a myth from those perceived as experts, even if they actually are not experts, makes a myth harder to question.

The inexplicit nature of the concept of mental illness also contributes to the perpetuation of this myth. Consider another myth: Can it really be *proved* evil spirits do not exist, and that they do not possess people? Even as perceived by those who believe in it, the concept of mental illness is as amorphous and difficult to pin down in specific terms as the idea of evil spirit possession. Some, like Millen Brand in an article in 1970 in *The Journal of Contemporary Psychotherapy* titled "Is Mental Illness a Myth?" argue *against* the notion that "because 'mental illness' isn't a medical or physical illness, it doesn't exist at all" (Summer 1970, Vol. 3, p. 13). Psychologist Vernon W. Grant, Ph.D., in his book *This Is Mental Illness* says this:

> There is, again, a certain tendency in popular thinking to suppose that mental illness includes something more than the symptoms. Thus a person is said to be doing or saying certain things because is mentally ill. The illness, supposedly, causes him to act and speak as he does. ... It would be misleading, however, to say that the abnormal ways of feeling and perceiving are caused by "mental illness." These ways of feeling and perceiving *are* the illness. Too often the term suggests a mysterious something *behind* the unusual behavior. [Beacon Press 1963, p. 4, italics in original]

Other mental health professionals argue there *is* a mysterious something behind, or causing, the person's behavior, or so-called symptoms, and that this mysterious something is a still undiscovered "chemical imbalance" in the brain or some other brain abnormality. They argue mental illness is, by definition, a disease of the brain, even if current science can find nothing wrong with the brains of supposedly mentally ill people. Mental health professionals can't agree among themselves about whether mental illness is physical or non-physical. Being a vague concept makes the concept of mental illness more difficult to disprove and reject than it would be if it were clearly defined.

Also helping to perpetuate the myth of mental illness is the desire of some people to avoid personal responsibility for their actions and their lives. These are the people who telephone or write to me hoping I will, as a lawyer, help them prove that because of their supposed mental illness they are not

responsible for something they did. These also are the people who go to a mental health professional and in effect say "Doctor, make me happy": It is much easier to swallow supposedly antidepressant pills than get a better education or a better job, or a better marriage or intimate relationship, or be cured of a serious health problem like cancer. People who neglect or mistreat their children sometimes rely on the concept of mental illness to relieve them of responsibility for how their children turn out as adolescents or adults. What have they done wrong? In many cases, the answer is *plenty*. But they prefer to believe a disease (mental illness) that "could happen to anyone" intervened and that "It's no one's fault."

Another reason, mentioned in my essay *Does Mental Illness Exist?*, is our discomfort with ignorance. When we don't understand the real reasons for something, we often create myths to give us an illusion of understanding. Believing a myth is more comfortable than acknowledging ignorance. For example, ancient man did not understand the *why* behind rain and therefore created the myth of the Rain God. As man gained a knowledge of meteorology and hence a true knowledge of the *why* behind rain, the Rain God was no longer needed, and the Rain God idea was discarded. Earlier in human history, being baffled by the thinking and behavior of some people, people theorized the existence of evil spirits or demons and created the myth of demon possession, the belief that people behaved strangely or wrongly because they were possessed by evil spirits. In the words of A. John Rush, M.D., "Deranged behaviors were typically considered curses from the gods by the Ancients... During the Dark Ages, Western civilization returned to beliefs in possession and supernatural forces as explanations for psychiatric disorders" ("Diagnosis of Affective Disorders" in *Depression Basic Mechanisms, Diagnosis, and Treatment*, Guilford Press 1986, p. 2). Today we attribute thinking or behavior we dislike and don't understand to mental illness. However, mental illness is just as much a myth as curses by gods or possession by evil spirits. Often we just don't know why people think or act as they do. Rather than acknowledge our ignorance, which makes us uncomfortable, we create myths such as evil spirits or mental illnesses to provide an explanation.

Why aren't all crimes considered mental illnesses or the result of mental illness? Some people *do* say "all criminals are sick." However, for those of us who don't agree with this viewpoint, the difference between crime and mental illness typically is this: When we feel we understand the motives behind the disapproved behavior, we make the behavior a statutory offense. When we do not understand the motives behind disapproved behavior, we cover up our ignorance of these motives by creating a myth—the myth of mental illness—and say mental illness caused the behavior (and punish the supposedly mentally ill person with involuntary "hospitalization" or an involuntary outpatient commitment order, and forced psychiatric "therapy" such as "involuntary medication", or involuntary guardianship of his person and property). The myth of mental illness deludes us into believing we understand the reasons for disliked behavior that we in fact do not understand.

Another reason for continued belief in mental illness is drug company advertising designed to convince everyone mental illness is biologically caused. Marcia Angell, M.D., former editor-in-chief of the *New England Journal of Medicine*, in her book *The Truth About Drug Companies—How They Deceive Us and What To Do About It* (Random House 2005, p. 88) approvingly quotes bioethicist Carl Elliott saying "The way to sell drugs is to sell psychiatric illness." Psychiatrist Colin A. Ross, M.D., makes a similar comment in his autobiographical book *The Great Psychiatry Scam—One Shrink's Personal Journey* (Manitou Communications, Inc. 2008, p. xv): "Whatever makes mental illness be

biological sells drugs." In *Saving Normal—An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (HarperCollins 2013, p. 104), psychiatrist Allen Frances says "Psychotropic drugs are now among the very top best sellers for the drug companies. Their stock prices would be cut by more than half were it not for the antipsychotics, antidepressants, stimulants, antianxiety agents, sleeping pills, and pain meds. ... At the very top of the Pharma hit parade are the antipsychotics at a resounding $18 billion a year." Do you think drug company executives and advertising departments will tell the depressing truth about their products if widespread awareness of the truth would cause their company stock to be worth less than half what it is now? It is more likely they are determined to maintain the myth that mental illness is biological and to hide the harm done by psychiatric drugs so they can continue to earn huge profits from selling psychiatric drugs. Advertising mental illness as biological when it is not to sell more psychiatric drugs may be unethical, but as Dr. Angell warns us in *The Truth About Drug Companies* (p. 250), "Drug companies are in business to sell drugs. Period." And drug companies have huge advertising budgets.

I believe one of the most important reasons the myth of mental illness persists is what I call *the inadequacy of rule of law*. "Rule of law" is a sacred concept in American jurisprudence. On the day she was sworn-in as a U.S. Supreme Court justice, Sonia Sotomayor spoke eloquently about how deeply and sincerely she believes in rule of law. With the exception of civil commitment and involuntary guardianship laws, laws that fail to put people on notice of what is required or prohibited are invalidated by American courts as *void for vagueness*. An example is *Papachristou v. City of Jacksonville*, 405 U.S. 156 (1972), wherein a unanimous U.S. Supreme Court overturned the decision of lower courts and declared a Jacksonville, Florida vagrancy ordinance unconstitutionally vague. The Supreme Court said this:

> This ordinance is void for vagueness, both in the sense that it "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute," *United States v. Harris*, 347 U.S. 612, 347 U.S. 617, and because it encourages arbitrary and erratic arrests and convictions. *Thornhill v. Alabama*, 310 U.S. 88; *Herndon v. Lowry*, 301 U.S. 242. Living under rule of law entails various suppositions, one of which is that "[all persons] are entitled to be informed as to what the State commands or forbids."

Judged by this standard, all laws authorizing civil commitment for mental illness, or loss of civil rights in involuntary guardianship (of adults), are void for vagueness and unconstitutional because they do not allow people of ordinary intelligence to know in advance what behavior or expression of ideas or outward display of emotions may result in losing their liberty or civil rights because of a "diagnosis" of mental illness and an involuntary inpatient or outpatient commitment or involuntary guardianship.

One might argue the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) delineates what is and what is not a mental disorder, and hence what speech and behavior is and is not allowed, and that therefore the *DSM* provides the constitutionally required notice of what the state commands or forbids. However, the "Cautionary Statement" at the beginning of *DSM-IV-TR* (p. xxxvii) explicitly *disclaims* the *Manual* provides guidance for legal purposes:

> It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in

> categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.

An introductory chapter in *DSM-5*, published in 2013, includes a similar disclaimer titled "Cautionary Statement for Forensic Use of DSM-5" (p. 25):

> ...it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals. ... When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual disability (intellectual developmental disorder), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis ... assignment of a particular diagnosis does not imply a specific level of impairment or disability. ... Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual's mental disorder or the individual's degree of control over behaviors that may be associated with the disorder.

Even if the *DSM* is nevertheless accepted as a valid standard for legal judgments, it fails to provide the constitutionally required notice of what the state commands and forbids, failure to comply with which may result in forced treatment or loss of liberty, because the *DSM* does not state which supposed disorders justify involuntary commitment, or loss of civil rights, and which do not.

Should a man with the *DSM-5* diagnosis "Male Hypoactive Sexual Desire Disorder" (*DSM-5,* p. 440), defined as "Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity" be involuntarily committed? It is an official mental disorder, but would anybody advocate involuntary commitment of a man only because he has no interest in sex? What about a woman with "Female Sexual Interest/Arousal Disorder (*DSM-5*, p. 433-437), which has a definition similar to that of the male version of this supposed disorder? Or looking back at *DSM-IV-TR* (published in 2000), how about diagnosis "315.00 Reading Disorder"?: "The essential feature of Reading Disorder is reading achievement (i.e., reading accuracy, speed, or comprehension as measured by individually administered standardized tests) that falls substantially below that expected given the individual's chronological age, measured intelligence, and age-appropriate education" (p. 51). Reading Disorder was carried forward into *DSM-5* as "Specific Learning Disorder...With impairment in reading" (*DSM-5*, pp. 66-67). How about involuntary treatment for *DSM-IV-TR* diagnosis "315.1 Mathematics Disorder" (p. 53), which has a definition similar to that of Reading Disorder? Mathematics Disorder was carried forward into *DSM-5* as "Specific Learning Disorder...With impairment in mathematics" (*DSM-5*, pp. 66-67). Or consider *DSM-IV-TR* diagnosis number "315.2 Disorder of Written Expression" defined as "writing skills...below those expected given the individual's chronological age...[etc.]", carried forward into *DSM-5* as "Specific Learning Disorder...With impairment in written expression"

(*DSM-5*, p. 66-67). Other examples are *DSM-IV-TR* diagnosis numbers 302.73 and 302.74, "Female Orgasmic Disorder" (p. 547) and "Male Orgasmic Disorder" (p. 550), both of which are defined as difficulty achieving orgasm, and both of which are official psychiatric diagnoses or disorders or diseases. "Female Orgasmic Disorder" also appears in *DSM-5* (p. 429). *DSM-5* defines the following as mental disorders: "Erectile Disorder" (p. 426), "Premature (Early) Ejaculation" (p. 443), and "Delayed Ejaculation" (p. 424). Would anybody advocate *involuntary* inpatient or involuntary outpatient treatment only because a man has any of these sexual "disorders"? Other examples are Tobacco Use Disorder (e.g., smoking too much, *DSM-5*, p. 571), Child Onset Fluency Disorder (Stuttering, *DSM-5*, p. 45), General Personality Disorder ("behavior that deviates markedly from the expectations of the individual's culture", *DSM-5*, p. 646), and Nightmare Disorder (*DSM-5*., p. 404). Might involuntary treatment be appropriate for someone with one of the "Circadian Rhythm Sleep-Wake Disorders" such as "Delayed Sleep Phase Type" (going to sleep very late and sleeping late into the next day, *DSM-5*, pp. 390-391) or "Advanced Sleep-Wake Type" (early to bed and early to rise, *DSM-5*, p. 393)? Like *DSM-IV-TR*, *DSM-5* does not state which of these or other supposed mental disorders qualify a person for involuntary hospitalization or involuntary outpatient treatment.

In *The Manufacture of Madness* (Harper & Row 1970, p. 68), psychiatry professor Thomas S. Szasz, M.D., says "psychiatry shows an unmistakable tendency to interpret all kinds of deviant or unusual behavior as mental illness." At one time, homosexuality was an example. Would it have been appropriate to subject all homosexuals to involuntary treatment prior to the American Psychiatric Association's vote in 1973 to de-designate homosexuality as a mental disorder? *DSM-II* (published in 1968, p. 44) said homosexuality was a mental disorder but did not say all homosexuals should be treated involuntarily if they refuse treatment for their homosexuality. However, it probably happened to homosexual adolescents whose parents were upset by their homosexuality. Some of those adolescents may even have been lobotomized as treatment for their homosexuality: In *Psychosurgery—Damaging the Brain to Save the Mind* (HarperCollins 1992, pp. 21 & 50), Joann Ellison Rodgers of The John Hopkins Medical Institutions says in the middle decades of the 20th Century—

> Rapists, pedophiles, homosexuals, exhibitionists, and transvestites were all candidates for lobotomies. ... Many lobotomies, for example, were performed on the institutionalized mentally ill to stop or limit 'bizarre' sexual behavior, which at that time meant masturbation, homosexuality, and for women, almost any overt desire for sexual release.

Similarly, in 2005 Emad N. Eskandar, M.D., G. Rees Cosgrove, M.D., and Scott L. Rauch, M.D., of Massachusetts General Hospital and Harvard Medical School said:

> Psychiatric neurosurgery was first introduced as a treatment for severe mental illness by Egas Moniz in 1936. ... despite a lack of objective therapeutic benefit, psychiatric neurosurgery was enthusiastically adopted by practitioners of the day. At the height of enthusiasm, psychiatric neurosurgery was recommended for curing or ameliorating schizophrenia, depression, homosexuality, childhood behavior disorders, criminal behavior and uncontrolled violence. ["Psychiatric Neurosurgery", neurosurgery.mgh.harvard.edu, accessed February 5, 2014, underline added]

Lobotomizing people as treatment for masturbation, homosexuality, or normal heterosexual desire is an example of harm caused by psychiatric "diagnosis" that is based on deviance from cultural norms or

values rather than demonstrated biological abnormality. It is also an example of why I call psychiatry evil.

I have uncovered no 21st Century reports of involuntary psychosurgery, but brain-damaging "medication" and electroshock are given to people over their objection every day in the U.S.A., either of which is capable of inflicting brain damage as severe as occurs with psychosurgery.

LOBOTOMY AS TREATMENT FOR HOMOSEXUALITY?

People are committed involuntary to mental hospitals every day in the U.S.A. because they have "suicidal ideation" despite the fact that neither the *DSM* nor civil commitment laws put people on notice they are allowed to think about some things but not other things. Where is it written, even in the *DSM*, that Americans are not permitted to even *think about* ending their own lives—and that if they do loss of liberty may be the consequence?

This leaves aside the equally important question of whether the there is a right to freedom of thought under U.S.A.'s First Amendment (made applicable to the states by the Fourteenth Amendment), similar state constitutional provisions (e.g., Article 1, Section 8 of the Texas Constitution), or constitutional provisions in other countries, that should take precedence over psychiatry's supposedly diagnostic (but actually only descriptive) classification system and the State's statutory involuntary commitment criteria.

It should be obvious that one of the purposes of the *DSM* is to allow mental health professionals to bill health care insurance companies and government programs such as Medicare and Medicaid for virtually anything (which is one reason health care insurance premiums are exorbitant, and one reason health care is bankrupting the government and the economy). Much normal human thinking and behavior at least arguably falls within a category of mental disorder in the *DSM*. The supposedly diagnostic (but actually only *descriptive*) criteria in the *DSM* are so broad many commentators and critics have correctly said there probably is no human being alive who falls within none of the *DSM's* various categories of mental disorder, and most people meet the criteria for several psychiatric diagnoses simultaneously. For example, "In court testimony, under oath, Jay Katz, a professor of psychiatry at Yale, admitted that 'If you look at DSM-III you can classify all of us under one rubric or another of mental disorder'" (quoted in Thomas Szasz, *Insanity—The Idea and It's Consequences*, Syracuse University Press 1997, p. 57). In his book *The Hyperactivity Hoax*, board-certified neurologist and psychiatrist Sydney Walker III, M.D., says "The other major flaw of DSM, related to the first, is that it labels virtually *everything* as some type of disorder. Thus, a child who sees a DSM-oriented doctor is almost assured of a psychiatric label and a prescription, even if the child is perfectly fine" (St. Martin's Press 1998, p. 23; italics are Dr. Walker's). According to Marcia Angell, M.D., Senior Lecturer in Social Medicine at Harvard Medical School and former editor-in-chief of *The New England Journal of Medicine*, in her endorsement on the dust cover of Dr. Allen Frances' book, *Saving Normal*, Dr. Frances "was once the most influential psychiatrist in the country, as head of the task force that compiled the last [fourth] edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM)". Yet even this highly esteemed psychiatrist, Dr. Frances, says he "met many other friends working on *DSM-5* who were similarly excited by their pet innovations and soon

discovered that I personally qualified for many of the new disorders that were being suggested by them for inclusion for *DSM-5*" (*Saving Normal—An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*, HarperCollins 2013, p. xvii). Dr. Frances cites "a study that found 83 percent of kids qualify for mental disorder diagnosis by the time they are twenty-one" (*Id.*, p. 177: *Journal of American Academy of Child and Adolescent Psychiatry*: "Cumulative Prevalence of Psychiatric Disorders by Young Adulthood: A Prospective Cohort Analysis from the Great Smoky Mountains Study", Vol. 50, No. 3, (2011) pp. 252-261). In their book *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs* (Transaction Publishers 2013, p. vii), three social work and social welfare professors (Stuart A. Kirk, et al.) say "According to the latest American Psychiatric Association methods of diagnosing mental illness, nearly one hundred million people, 25 to 30 percent of the US population, have a mental illness during any one year, and half of the population will have a mental illness during their lifetime." Similarly, in 2011 Dr. Vernon Coleman, a British physician, wrote that "diagnostic symptomotology is so vague and far reaching that I could, without much difficulty, find some definable mental illness in every person in the UK" (*Do Doctors and Nurses Kill More People Than Cancer?*, European Medical Journal 2011, p. 32). In *Whores of the Court: The Fraud of Psychiatric Testimony and the Rape of American Justice* (ReganBooks 1997, p. 250), Boston University psychology professor Margaret A. Hagen, Ph.D., says "The newest (1994) *Diagnostic and Statistical Manual of Mental Disorders* provides the civil litigant with literally hundreds of possible disorders, each neatly laid out with the necessary symptoms. It is hard to imagine that anyone could live in today's society and not be diagnosed with at least one of these many disorders."

THE *DSM* LABELS VIRTUALLY *EVERYTHING* AS SOME TYPE OF DISORDER

DSM-5 broadens the categories of mental disorder even more than *DSM-III*, *DSM-IV* or *DSM-IV-TR*. According to Dusan Kecmanovic, professor of psychiatry and political psychology at Sarajevo University, "it will be difficult to be normal after the publication of DSM-5" ("DSM-5: The More It Changes The More It Is the Same", *Psychiatria Danubina*, 2013; Vol. 25, No. 2, pp. 94-96). (Americans should keep this in mind when considering laws to keep guns out of the hands of the "mentally ill": Since nearly everyone qualifies as mentally ill under current criteria, such laws could in application be a *de facto* repeal of the Second Amendment.) In her book, *The Trouble With Drug Companies*, Dr. Marcia Angell says "few psychiatric disorders have objective criteria for diagnosis" (p. 88). Actually, none do. The vague, unreliable, unpredictable, and invalid nature psychiatric diagnosis enables and encourages arbitrary "diagnosis" and arbitrary involuntary treatment. That violates the constitutional standard stated by the Supreme Court in *Papachristou*.

The constitutional law requirement that government must tell you what is and is not allowed before it may do anything to you as a consequence of your failure to act as expected is only fair. That's why the U.S. Supreme Court has declared it to be constitutionally required.

There is, however, a problem with this constitutional requirement, or said another way, there is a problem with rule of law: We can't always anticipate and articulate, in advance, everything a human being might possibly say or do that other human beings, upon being made aware of it, will consider

unacceptable.

This epiphany came to me in 1992 when I was sitting at a table in a restaurant in Manhattan with the woman I was dating at the time. Our table was located next to a window on the other side of which was a sidewalk. A man who looked like he was homeless put his face very close to the window as he stared at us, pointed at us, made funny faces, and did an odd sort of dance. His behavior was distracting and inappropriate, but how would one write a law prohibiting what he was doing?: Don't look into or get too close to restaurant windows? Don't point at people? Don't make funny faces? Don't dance on the sidewalk? Similarly, I once saw a man sleeping on the floor in a hotel corridor with his face against a dirty carpet. At first I thought he might be dead, but after several seconds of observation I could see he was breathing. I advised the hotel front desk clerk who roused the man and told him he couldn't sleep there and told him to go sleep in his hotel room. The next day in a Subway Sandwich Shop a patron who looked like he was homeless began singing loudly and vastly off-pitch along with the music playing on speakers in the ceiling of the shop, disturbing everyone in the shop. Examples abound in the evidence introduced at involuntary commitment and involuntary guardianship hearings. After I think I've heard and seen everything, the behavior or ideas of a proposed patient in an involuntary commitment for supposed mental illness or of the proposed adult ward in an involuntary guardianship trial confronts me with yet another example of unacceptable thinking or behavior I wouldn't have thought of had I been given the job of writing a state's criminal code and other laws. *It is largely because of this difficulty that we have the concept of mental illness*. Sociologist Thomas Scheff has defined mental illness as "residual rule-breaking": "After crime," wrote two of his critics, "perversion, drunkenness, bad manners, there are always those diverse grab-bag violations for which the culture has no explicit label—the 'residual rules' broken by those deemed mentally ill" (Rael Jean Isaac & Virginia C. Armat, *Madness in the Streets*, Free Press/Macmillan 1990, p. 49). The concept of mental illness allows us, as a society, to impose sanctions, that is, punishment (called "therapy") on law-abiding people who fail to live in accordance with our expectations about what conduct people should and should not engage in, and what beliefs or thoughts people should or should not express. As psychiatry professor Thomas Szasz said in 1994, "when I grew up in Hungary—1920s, 1930s—it was very, very clear that psychiatry was essentially a jail function. There were blue coated policemen and white coated policemen." ("Thomas Szasz on Socialism in Health Care", YouTube.com at 1:24:42). In "Mental Illness as Brain Disease: A Brief History Lesson", Dr. Szasz says "The contention that mental illness is brain disease is as old as psychiatry itself: it is an integral part of the grand lie that psychiatry is a branch of medicine and healing, when in fact it is a branch of the law and social control" (szasz.com, accessed August 2, 2014). Similarly, in 2011 three authors including psychology professor Mark Rapley and psychiatrist Joanna Moncrieff call psychiatry "the enterprise of policing human conduct" (Rapley, et al., *Medicalizing Misery*, Palgrave Macmillan 2011, p. 4). British psychiatrist Suman Fernando says "psychiatry...from the very beginning...has been concerned with social control" (*Id*., p. 50). In *Madness—A Brief History*, Roy Porter, Professor of the Social History of Medicine at the University College, London says "To many the psychiatrist seemed to have been reduced to acting as society's policeman or gatekeeper, protecting it from the insane" (Oxford University Press 2002, p. 186). The role of psychiatrists as police is also underscored by the subtitle of Louise Armstrong's book *And They Call It Help—The Psychiatric Policing of America's Children* (Addison-Wesley Pub. Co. 1993). Blue-coated police enforce written laws. White coated police—psychiatrists—enforce

*un*written laws prohibiting thinking and behavior we either didn't think to write a law against or choose not to (for reasons discussed below) or for which we just can't find the right words (like my above examples). Psychiatry's roles as (1) part of the medical profession and (2) *de facto* police who enforce society's unwritten laws are obfuscated and confused, resulting in violators of society's unwritten laws not having the benefit of the protections that exist in criminal law. Violating society's unwritten laws is called mental illness or disorder. The punishment is imprisonment called involuntary hospitalization, psychological and physical misery and brain damage caused by "involuntary medication" or involuntary electroconvulsive "therapy".

Oddly, violators of our *un*written laws tend to be punished more harshly than those who violate our *written* laws: Would anyone advocate drug or electroshock induced brain damage as punishment for bank robbery or even murder? Our current approach circumvents the difficult task of defining, in advance, what is and is not permitted and permits us to impose especially severe punishments. It is easier to call people mentally ill and incarcerate and punish them with supposed treatment for their supposed mental illness than it is to anticipate everything people might do that is unacceptable and enact laws prohibiting the behavior.

PSYCHIATRISTS AND THEIR CO-WORKERS ARE WHITE-COATED POLICE WHO ENFORCE SOCIETY'S *UN*WRITTEN LAWS

Sometimes belief in mental illness, or a pretense there is such a thing as mental illness, is the only way we can impose sanctions for disliked speech or behavior because, if we were to write laws clearly describing what is prohibited, it would be obvious we are violating the constitutional rights of the accused with such laws. For example, people are often forced into psychiatric "treatment", including involuntary hospitalization, because of what they say rather than because of what they do. Does this violate the First Amendment guarantee of freedom of speech? Does the First Amendment protect only speech other people consider sane or rational?

Refusing to speak when other people think you should is another example. In 2011 I was an observer at an involuntary commitment hearing of a man whose "Selective Mutism" (rarely saying a word to anyone, *DSM-IV-TR* diagnosis 313.23, p. 125) was his main supposed symptom of supposed mental illness, and at that hearing (after expiration of the time he could be held on a criminal charge) he was involuntarily committed to Kerrville State Hospital. In *Wooley v. Maynard*, 430 U.S. 705 at 714 (1977), the U.S. Supreme Court said "the right of freedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all." *Texas Jurisprudence*, a legal encyclopedia, says "Liberty of silence is included by the guarantee of liberty of speech" (9 Tex.Jur. Constitutional Law §91, p. 525). Because it would be unconstitutional, nobody is going to write a law saying *you must speak with people*. Nevertheless, engaging in normal conversation with those around you is an expectation nearly everyone has. Therefore, mutism or selective mutism can become "mental illness" motivating involuntary "treatment" and did in this case despite the constitutional right to, in the U.S. Supreme Court's words, "refrain from speaking at all." It is possible to incarcerate a person because he exercises a constitutional right such as refusing to talk if the *ostensible* or supposed reason is "mental illness" rather than the constitutionally

protected action or inaction.

We *could* enact criminal laws against mutism, or unconventional religious or philosophical beliefs, or converting to a religion your family abhors, or loudly expressing nonreligious beliefs most people disagree with, or being grandiose or obnoxious, or revealing oneself to be excessively unhappy ("depressed"), or talking aloud to oneself with others present, or admitting to thinking about suicide, or attempting suicide. We don't, because writing such laws wouldn't seem right. In many cases such laws would be an admission of how narrow-minded, intolerant, authoritarian, and even despotic we sometimes are, including in nations like the United States of America where freedom is frequently touted as the reason for American patriotism. Frequently, such laws would be impossible to reconcile with America's First Amendment guarantee of freedom in thought and expression or similar guarantees in other democracies and Article 19 of the United Nations Universal Declaration of Human Rights adopted by the United Nations General Assembly in Paris on December 10, 1948:

> Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media...

State and federal laws authorizing civil commitment for mental illness in the United States of America and other nations routinely violate this right to freedom of opinion and expression. Freedom of thought, opinion, and expression is respected in the U.S.A. if a person thinks Jesus is the Son of God but not if he thinks *he* is the Son of God, or if he thinks others are persecuting him (and others disagree), or if he thinks his life is not worth living (and others disagree), or if he has other thoughts other people consider crazy or bothersome. As psychiatry professor Thomas Szasz wrote in 1973: "If you talk to God, you are praying; If God talks to you, you have schizophrenia" (*The Second Sin*, Anchor/Doubleday 1973, p. 113). We on the Western side of what was once (prior to the breakup of the USSR) called the Iron Curtain like to think of ourselves as freedom-loving people who uphold human rights. The concept of mental illness permits us to violate our professed values about freedom and disregard the principal of rule of law without admitting to ourselves this is what we are doing. It permits us to violate what the American Declaration of Independence of July 4, 1776 says are the God-given and unalienable rights of all men (and women): "...that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness." The myth of mental illness permits us to deprive law-abiding people of their supposedly unalienable right to liberty and pursuit of happiness, and because of fatal effects of psychiatric "treatment" such as sudden death caused by neuroleptic "medications" effect on the heart, or neuroleptic malignant syndrome, or electroshock, or physical restraint (causing asphyxiation), sometimes even their right to life, by pretending we are "treating them for their mental illness." Ron Leifer, M.D., a psychiatrist, said it well in an article titled "A Critique of Psychiatry and an Invitation to Dialogue" in *Ethical Human Science and Services*, December 27, 2000 critpsynet.freeuk.com:

> The problem is that society demands a greater degree of social control than law allows. The public wants to be protected from unconventional, threatening, and dangerous behavior. There is, thus, a public mandate for a covert form of social control which supplements rule of law. Medical-coercive psychiatry, in alliance with the state, performs this function disguised as medical diagnosis and treatment. ... involuntary, coercive psychiatry serves society by providing a supplemental form of social control which, because it is

> covert or disguised, preserves our national pride by giving us the appearance of being a nation of free individuals under law. On the other hand, when the covert is exposed it can be seen to violate the honored values on which this nation was founded.

An example that was prominently featured in news reports in New York City in 1987 was the use of the concept of mental illness to get homeless people off the streets and out of the public parks of the City. A *New York Times* article called it "a Koch administration program to involuntarily hospitalize severely mentally ill homeless people living on city streets" (Josh Barbanel, "New York Ordered to Find Care for Homeless Woman", *The New York Times*, November 25, 1987, p. B3). Rather than admit the real motive was getting rid of these people whose presence was irritating to other people, New York City Mayor Ed Koch asserted the purpose was to get them "hospitalized" (involuntarily, of course) for allegedly needed "mental health" treatment. It was a classic case of oppression disguised as benefaction. New York lawmakers *could* have created a law making it illegal to be homeless or to sleep on park benches, sidewalks, or in subway stations and swept homeless people into detention facilities of some kind. But they couldn't or didn't want to accept the moral implications of such a choice and therefore preferred to use supposed mental illness as an excuse to justify incarcerating homeless people. This was intellectually dishonest, because the real reason was disapproval of or annoyance with homeless people, and because imprisonment does not become benign merely because it is called hospitalization.

Even if it were possible to anticipate everything people might do that we as a society want to prohibit, and even if we didn't care if writing such laws clearly and explicitly reveals we are violating human and constitutional rights with such laws, in many cases it would be impossible to write a statute that would prohibit the behavior we want to prohibit without encompassing other behavior we do *not* want to prohibit. An example is crying in public. A person who cries in public too often, or for reasons with which few others sympathize, or for reasons others don't understand, bothers other people. Few would advocate making it illegal to cry in public, because there are circumstances in which most people think crying in public is understandable and acceptable and shouldn't be prohibited. People are expected to intuitively know when it is okay to cry in public and when it isn't. A person who cries in public for reasons with which others are unsympathetic or at times others dislike, or more often and more loudly than other people think is appropriate, is breaking a *residual rule* of behavior, that is, a rule that isn't written anywhere but which people are nevertheless expected to know about and abide by. Violating this unwritten expectation may result in punishment called involuntary psychiatric treatment, including involuntary "hospitalization" for major depressive disorder or some other supposed diagnosis. How and when and how loudly to express one's anger, even verbally and without threatening others with physical harm, is also the subject of *residual rules* of conduct the violation of which might result in involuntary psychiatric "treatment", including involuntary "hospitalization" or an involuntary outpatient commitment court order compelling a person living in his own house or apartment to appear at a clinic for bi-weekly or monthly injections of a long-acting drug intended to treat a supposed mental illness such as inappropriately expressed anger.

THE CONCEPT OF MENTAL ILLNESS PERMITS US TO VIOLATE OUR PROFESSED VALUES ABOUT FREEDOM

AND RULE OF LAW WITHOUT ADMITTING TO OURSELVES THIS IS WHAT WE ARE DOING

In a letter dated October 14, 2009 I proposed the above ideas to retired psychiatry professor Thomas S. Szasz, who I had shortly before visited in his home town of Manlius, New York:

> I believe the reason the myth of mental illness continues is not only or even mainly because people do not understand its scientific invalidity, although that is of course a factor. I believe one of the most important reasons the concept of mental illness continues to be accepted legally and otherwise is it is impossible to write into criminal codes and other laws all commonly held expectations of behavior—and people's desire to enforce these unwritten expectations. Mental illness is the rationalization used to punish people who violate unwritten rules—with punishment called involuntary hospitalization, and with torture inflicted as punishment but called treatment for the supposed but actually nonexistent "mental illness". ... I think overcoming this problem is an important challenge facing people like you and me who want America and other nations to be governed by rule of law rather than arbitrary after-the-fact determinations of what behavior was right or wrong.

With my above letter I gave Dr. Szasz a tape recording I had made of the speeches including his own at the Thomas S. Szasz Tribute Dinner I had attended in Manhattan in 1990. Dr. Szasz's reply in an e-mail on 10/19/2009 was "Dear Mr. Ramsay, Many thanks for the tape - and your letter, with which I agree completely. Marginal rule violation and its punishment is the name of the game. Best wishes, Thomas Szasz"

MARGINAL RULE VIOLATION AND ITS PUNISHMENT IS THE NAME OF THE GAME _____

We as a society and as citizens of democracies would be more honest if we discard the myth of mental illness, repeal our civil commitment laws, and in their place enact a criminal law that openly acknowledges legislators are unable to anticipate and write a law against every act that should be prohibited. Such a law might be titled "Criminal Conduct NOS". It seems the majority of psychiatric diagnoses in involuntary civil commitment for mental illness I have seen end with the letters NOS, e.g., Personality Disorder NOS or Psychotic Disorder NOS. In his book *Hippocrates Cried: The Decline of American Psychiatry* (Oxford University Press 2013, p. 39), psychiatrist Michael Alan Taylor, M.D., says "upward of a third of psychiatric patients end up being given the label NOS (Not Otherwise Specified)." Even with the ever-increasing number supposedly diagnostic categories with each new edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, resulting in each edition being a bigger book with more diagnoses (or descriptions) than the last, psychiatrists continue to find it necessary to use "NOS" diagnoses. If we are going to incarcerate people on the basis of a supposed diagnosis ending with the letters NOS, why not have a criminal law with a name ending in NOS that does the same thing? Criminal Conduct NOS might be defined as *"an act not mentioned in this Penal Code but which the defendant knew or if he was a reasonable person of ordinary intelligence would have known he should not have performed."* Replacing civil commitment

law with a criminal or penal code provision such as Criminal Conduct NOS would represent a *constriction* of the power of families and government to incarcerate and punish people for (otherwise) lawful but bothersome behavior, or what Dr. Szasz called marginal rule violation, compared with today's laws authorizing civil commitment for supposed mental illness, for these reasons: To obtain a conviction for Criminal Conduct NOS, the prosecution would be required to prove the defendant was guilty of *specific <u>past</u> act* rather than allowing imprisonment (called involuntary "hospitalization") and corporal punishment and psychological torture (called involuntary "medication" or involuntary electroshock) for an alleged, arbitrarily and often vaguely defined state of mind such as depression or schizophrenia or bipolar or personality disorder, or predicted *future* conduct—"dangerousness". The "clear and convincing" standard of proof permitted by the U.S. Supreme Court in civil commitment for supposed mental illness in *Addington v. Texas*, 441 U.S. 418 (1979), and employed in many states of the U.S.A., would be replaced with the more stringent standard of proof "beyond a reasonable doubt" that applies in criminal cases. Most Americans have a right to trial by jury in civil commitment for mental illness, but many do not. If civil commitment laws are repealed and Criminal Conduct NOS added to each state's criminal code, the defendant's right to trial by jury would be respected to the same extent it is in other criminal cases, because legislators and judges would no longer be playing word games or employing deceptive semantics to avoid respecting defendants' constitutional rights, including the right to trial by jury, by calling the proceedings "civil" or "special" rather than criminal. The judge or jury would be required to find the defendant not only did the act alleged but knew, at that time, what he did was wrong or that a reasonable person of ordinary intelligence would have known what he did was wrong. To avoid convicting a person who lacked the mental capacity of a reasonable person of ordinary intelligence of a "criminal" offense, the judge or jury would have to be empowered to find the defendant did the act alleged, that a reasonable person of ordinary intelligence would have known the act was wrong, but that the defendant lacked the mental capacity of a reasonable person of ordinary intelligence, withhold adjudication of a "criminal" offense, and sentence the defendant to a type of incarceration or program deemed educational or therapeutic.

Some will object to this approach because it does not allow intervention to prevent future acts. My response is we can't predict a person's future conduct reliably enough to justify incarceration as a preventive measure. In the words of a clergyman whose Sunday sermon I saw on C-Span on January 1, 2012, "The only evidence of what a person will do in the future is their record of what they have done in the past" (Rev. Bill Tvedt, Jubilee Family Church, Oskaloosa, Iowa). A person's future conduct cannot be proved by *any* burden of proof, not even "preponderance of the evidence", unless perhaps he *says* he is going to do something, or he has a long history of similar acts in the past. (See *Is Involuntary Commitment for "Mental Illness" or "Dangerousness" a Violation of Substantive Due Process?*) Substituting a criminal law titled Criminal Conduct NOS for current civil commitment law is only a partial solution, because sometimes people's behavior is bothersome but does not justify criminal prosecution, including Criminal Conduct NOS. Enforcement of private property rights that give property owners authority regarding what can be done on their property may be the best solution in some situations.

In summary: Because there is no credible evidence of any so-called mental illness being caused by biological abnormality, so-called mental illness is definable only as thinking or behavior that is considered unacceptable. Without a biological abnormality proved to be the cause of the behavior or

supposed symptoms, a supposed mental illness does not qualify as true illness or as true disease. The word "mental" *implies* non-physical: A person can no more have "mental illness" than he can have *mental cancer*. It is possible to have brain cancer but not mental cancer. For similar reasons, it is possible to have a brain disease but not a mental disease. Likewise, it is no more possible to have a "mental" illness than it is possible to have a "religious illness" or a "political illness". Religious and political thinking are aspects of mentality, and in fact many people are subjected to involuntary commitment because of ideas they consider religious. Mental illness does not exist, except as a concept in the minds of people who believe in mental illness. Involuntary psychiatric "therapy" is punishment for thinking or behavior people dislike, not health care as people like to think and as legislators and judges assume. If the so-called professionals in what we call mental health allowed themselves to use only the term *brain disease* (not "mental illness") and refused to believe a brain disease is present unless true *physical, biological* (not merely mental, emotional, or behavioral) evidence is found, most if not all psychiatric and psychological "diagnosis" (confusing values with health) would cease. But then, as psychiatrist Ronald Leifer points out (above), we as a society would be stuck with rule of law, and "the public will be deprived of an extra-legal means of maintaining domestic tranquility" ("A Critique of Psychiatry and an Invitation to Dialogue", *Ethical Human Science and Services*, December 27, 2000, www.critpsynet.freeuk.com/critique.htm, accessed March 9, 2013).

Belief in mental illness continues for all the above reasons, none of which are valid from a logical or scientific or legal and constitutional standpoint.

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Psychiatric Drugs: Cure or Quackery?

81–103 minutes

Psychiatric drugs harm the brain, often permanently. Psychiatric drugs have no beneficial effects for those who take them (except, sometimes, a placebo effect, if taken in a dose low enough for their toxic effects to not be pronounced—or relief of withdrawal symptoms when attempting to reduce dosage or stop taking the drug). Psychiatric drugs and the physicians, physician assistants, nurse practitioners, and (in some states of the U.S.A.) psychologists who prescribe them, and judges who order their

administration, are dangers to your health. Legislators and governors who enact laws authorizing "treatment over objection" with psychiatric drugs, and judges who approve involuntary psychiatric "medication" orders, and those who carry out the orders, are subjecting people to misery and to brain-damage that is often not reversible, and they are violating human rights. Because government licensing of health care practitioners exists to protect the public from harmful or unscientific treatment, the use of psychiatric drugs *by licensed practitioners* should be **prohibited by law**—except for patients who are already addicted to a psychiatric drug and need to be withdrawn slowly, or who must continue taking a drug for life to avoid intolerable withdrawal symptoms.

Most of what you need to know about psychiatric drugs or "medications" is found in a 457 page book published in 2008 by psychiatrist Peter R. Breggin, M.D., *Brain-Disabling Treatments in Psychiatry, Second Edition* (Springer Publishing Company):

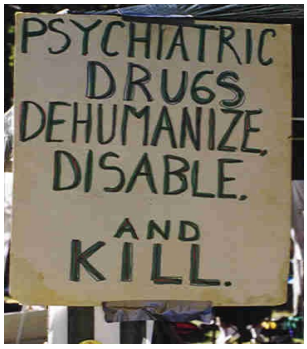
As Dr. Breggin further states in a video available on his web site, breggin.com, and on YouTube.com, "Simple Truths About Psychiatry—How Do Psychiatric Drugs Really Work?" (Part 2, at the 8 minutes and 18 seconds point), "If you're getting an effect from a psychiatric drug, it's a disabling effect." In *The Antidepressant Fact Book* (Perseus 2001, p. 168), Dr. Breggin says "If a drug has an effect on the brain, it is harming the brain. Science has not found or synthesized any psychoactive substances that improve normal brain function. Instead, all of them impair brain function." In 2011, Harvard psychiatry professor Blaise A. Aguirre, M.D., whose biography claims he is an expert in psychopharmacology, in a lecture about borderline personality disorder (BPD), said "almost everybody" who comes into his adolescent treatment unit at McLean Hospital (a psychiatric hospital in Massachusetts) as a patient comes in "on polypharmacy" and that because of this "they're so shut down" and are "a zombie" and that the only way to help them with psychotherapy (that is, by talking with them) is to withdraw them from psychiatric drugs. He said "about a quarter [of his patients] leave [his psychiatric treatment unit] on no medications and just feeling a lot better" and that "There's no evidence that [psychiatric] medication is going to add capacity that you didn't have to start with" ("BPD In Adolescence: Early Detection and Intervention" at the National Education Alliance Borderline Personality Disorder conference in Atlanta, Georgia, November 4, 2011, YouTube.com, 35:15 to 36:30). Whether intentionally or not, Dr. Aguirre's remarks acknowledge psychiatric drugs always *subtract* from or *reduce* mental functioning and never *add* to or improve mental functioning as well as making people feel worse rather than better.

IF YOU'RE GETTING AN EFFECT FROM A PSYCHIATRIC DRUG, IT'S A *DISABLING* EFFECT.

As Dr. Breggin makes clear in *Brain-Disabling Treatments in Psychiatry* and several other books, and as journalist Robert Whitaker documents in *Anatomy of an Epidemic* (see Recommended Reading at the end of this essay), and as I will show in more detail in what follows, *psychiatry has no medications*. Psychiatry has *drugs*. While it isn't apparent from their medical dictionary definitions, as the words have come to be used, "drug" and "medication" are not entirely synonymous. The word "medication" implies benefit. The word "drug" does not necessarily. For example, heroin and cocaine are drugs, but I've never seen or heard anyone call either a medication. This is why advocates of

psychiatric drugs usually call them "medication" and critics usually call the same substances "drugs". All medications are drugs, but a chemical or compound can be a drug without being a medication. All of psychiatry's drugs fall outside the usual meaning of the word *medication* because they do not help and in many if not most cases inflict harm. Another reason psychiatric drugs are not medications is medication, by the usual definition, cures or reduces the symptoms of a disease (a disease, or illness, being an abnormality of the body that impairs its function), and no psychiatric drug does that. As Dr. Peter Breggin says (in the last sentence of the above indented quote), in psychiatry, "medication" is something that *gives you a disease*.

The idea of a mentally ill person being "stabilized on medication" is a myth perpetrated by pharmaceutical companies seeking to maximize profits by selling more of their "medications", biologically oriented psychiatrists and psychologists who prescribe them, drug company financed advocacy groups such as the National Alliance on Mental Illness (NAMI), and script writers for television shows and motion pictures who in their fictional accounts portray mentally ill people as violent or irrational when they stop taking their "medication". The reality is today people called mentally ill are not "stabilized on meds" but *disabled by drugs*. Because of their sedating effects, psychiatric drugs *can* temporarily suppress violent, irritating, or vexing thinking or behavior, but they also cause temporary and *permanent* damage to the brain and eventual behavioral problems and increase risk of death in persons taking them. Being not only neurotoxic but *cytotoxic* (which means poisonous to living cells in general), psychiatric drugs often harm not only the brain but harm other parts of the body, too. In *Your Drug May Be Your Problem—How and Why to Stop Taking Psychiatric Drugs* (Perseus Books 1999, p. 81), psychiatrist Peter Breggin and clinical social work professor David Cohen say neuroleptic or "anti-psychotic" drugs "subject almost every system in the body to impairment. Research, including a recent study, indicates that these drugs are toxic to cells in general."



Testimony of psychiatrists and patients in involuntary civil commitment and treatment-over-objection hearings give the impression that about 90% of hospital psychiatry today consists of psychiatrists trying to force people to take their so-called medications and the "patients" trying to avoid them. Most psychiatric drugs make people feel miserable, so most people resist taking them. Psychiatric drugs are so harmful they should be taken by nobody, but they are *forced* upon patients in psychiatric hospitals. Many people living outside hospitals are court-ordered to take psychiatric drugs while living in their own homes or as a condition of release from a psychiatric hospital.

Punishing people by compelling them to take psychiatric drugs that make them feel bad and harm their health, while falsely believing or pretending the drugs are treating an illness, may force people to change their (outwardly expressed) ideas or their behavior to avoid this punishment, but this

is not health care.

In his article, "A Critique of Psychiatry and an Invitation to Dialogue" (published in *Ethical Human Science and Services*, December 27, 2000), psychiatrist Ron Leifer, M.D., asks, "If mental illness is a social construct rather than a bodily illness, then questions naturally arise about the use psychiatric drugs. What does it mean to prescribe a drug for a metaphorical illness?" It means the use of psychiatric drugs is pseudoscience and quackery.

Because psychiatric drugs interfere with normal functioning of the brain (and hence the mind) and other parts of the human body and do not treat any bona-fide disease, their use is health care quackery, not health care.

PSYCHIATRY HAS HARMFUL DRUGS BUT NO TRUE *MEDICATIONS*

In the 1970s when I sat in on a psychiatry class with a medical student friend, the professor told us "Research has shown we do not need to sleep, but we do need to dream." According to Jessica Payne, Ph.D., associate professor of psychology and director of the Sleep, Stress, and Memory Lab at the University of Notre Dame, "during sleep, your mind and body are actually highly active with processes critical for your physical and mental health. ... sleep is as important to your well-being as diet and exercise" (quoted in *Real Simple* magazine, realsimple.com, August 2014, p. 105 at 106). The dream phase of sleep, called the rapid eye movement (REM) phase, is the critical part. Contrary to the claim psychiatric drugs such as major and minor tranquilizers, so-called antidepressants, and mood stabilizers are useful as sleeping pills, their real effect is to inhibit or block *real* sleep, particularly the critical REM or dream phase. In an article titled "The Effects of Antidepressants on Sleep", Andrew Winokur, M.D., Ph.D., Professor of Psychiatry and Director of Psychopharmacology at the University of Connecticut, and Nicholas DeMartinis, M.D., Assistant Clinical Professor at the University of Connecticut and an employee of Pfizer, Inc., say "Virtually all of the SSRIs [Selective Serotonin Reuptake Inhibitor antidepressants] have been noted to suppress REM sleep". They say "The majority of TCAs [Tri-Cyclic Antidepressants] markedly suppress REM sleep" and that the MAOIs (MonoAmine Oxidase Inhibitors) Phenelzine and Tranylcypromine used as antidepressants "have been demonstrated to produce REM suppression". They also say "with the selective SNRIs [Serotonin and Norepinephrine Reuptake Inhibitors, which is another class of supposedly antidepressant drugs], the general pattern of effects reported are ... disruption of sleep continuity and prominent suppression of REM sleep" (psychiatrictimes.com, June 13, 2012). In his lecture at the 2011 Empathic Therapy Conference in Syracuse, New York, psychiatrist and psychoanalyst Douglas C. Smith, M.D., of Juneau, Alaska said this:

> Dreaming, it turns out, is absolutely essential to life. We cannot live without dreaming. There are experiments where you can deprive people of REM sleep, and they go crazy very quickly. If you do it with lab animals—'cause all mammals have REM sleep dreams—if you deprive lab animals of REM sleeping, they die sooner than they would of starvation. So we need to dream more than we need to eat. ... I worry about psychiatric medicines because—for many reasons, but here's another one, if you hadn't thought of this one—all

> psychoactive substances impair dreaming. They all inhibit or impair in some way the normal dreaming process, the REM cycle. You can see it with EEGs and the sleep studies. Even sleeping pills impair normal sleeping.

A self-help magazine advises: "Do not take sleeping pills unless under doctor's orders, and then for no more than 10 consecutive nights. Besides losing their effectiveness and becoming addictive, sleep-inducing medications reduce or prevent the dream-stage of sleep necessary for mental health" (*Going Bonkers?* magazine, premiere issue, p. 75). In his autobiography, Pulitzer Prize winning writer William Styron says after taking Nardil, Halcion, and Ativan, he did not dream for "many months" (*Darkness Visible*, Random House 1990, pp. 60, 70, 71, 75). Sleep deprivation experiments on normal people show loss of sleep causes hallucinations if continued long enough (according to Maya Pines in her book *The Brain Changers,* Harcourt Brace Jovanovich 1973, p. 105). So what would seem to be one of the likely consequences of taking drugs, such as psychiatric drugs, that inhibit or block real sleep? In psychiatry, where words and phrases imply or suggest the opposite of the truth, drugs that suppress the rapid eye movement or REM or dream phase of sleep, making a person more susceptible to hallucinations, are called "antipsychotic"! Many psychiatric drugs induce what looks like sleep to an uninformed or miseducated observer (which seems to include most mental health professionals), but the drugs actually induce a dreamless unconscious state—not sleep. By impairing REM sleep, psychiatric drugs cause rather than cure what is typically thought of as mental illness, which as Robert Whitaker documents in his book *Anatomy of an Epidemic* (Crown Publishers 2010), has become epidemic rather than being reduced or eliminated during psychiatry's psychopharmaceutical era starting in the 1950s and 1960s and continuing to the present day.

IN PSYCHIATRY, "MEDICATION" *GIVES* YOU A DISEASE (RATHER THAN CURING or TREATING ONE)

Psychiatrist Douglas C. Smith also said this in the aforementioned lecture:

> If you look at the research on lab animals that get deprived of REM sleep, they become kind of psychotic. They become aggressive. They can be violent. They actually become more, they call it, more instinctually driven. They want sex more, indiscriminately. They eat more. And they become more aggressive. Well, who does that remind you of? You know, of people that are on psychiatric drugs. I've heard stories today [at this conference] about some people that have become extremely violent—suicidal or aggressive [while taking psychiatric drugs]. ... One thing that's coming out in the psychiatric literature, there's more awareness now, especially with antidepressants—I think it might be *all* psychiatric drugs, psychoactive substances—but with antidepressants, there's data that with long-term use you have chronic insomnia. And boy, do I see that, more and more it seems like I'm seeing it [in my clinical practice].

The most dramatic examples of harm from psychiatric drugs are the deaths they cause, such as from neuroleptic malignant syndrome, neurological and cardiac problems caused by psychiatric drug toxicity, and people who become violent or suicidal when under the influence of a psychiatric drug who would not be if left in their normal unmedicated state. The effect of psychiatric drugs on the rapid eye

movement phase of sleep is one explanation for psychiatric drug induced impulsivity, violence, suicide, and homicide. Another is something called frontal lobe syndrome.

In his book *Borderline Personality Disorder in Adolescents* (Fair Winds Press 2007, p. 82) Harvard psychiatry professor and medical director of the Adolescent Dialectical Behavioral Therapy Center at McLean Hospital Blaise A. Aguirre, M.D., says this about the frontal lobes of the brain:

> **The Frontal Lobes**
>
> The frontal lobes are the part of the brain entrusted with executive function. This includes the ability to accomplish the following:
>
> • Recognize future consequences resulting from current actions
> • Choose between good and bad actions
> • Hold and weigh opposing viewpoints
> • Override and suppress unacceptable social responses
> • Determine similarities and differences between things or events ...
>
> People who have had accidents or trauma that have damaged their frontal lobes often display irritability, impulsivity, and angry outbursts.

Do psychiatric drugs damage or disable the frontal lobes of the brain, causing people taking them to display "irritability, impulsivity, and angry outbursts" in the form of violence, homicide, and suicide? Psychiatrist Grace Jackson, M.D., suggests exactly this in her book *Rethinking Psychiatric Drugs* (AuthorHouse 2005, pp. 125-127, bold print in original):

> A second possible mechanism of antidepressant-related suicide involves the impairment of activity within the frontal lobes. These brain regions are believed to be the critical centers of personality, impulse control, and executive functioning. Several teams of clinicians have been trailblazers in documenting the appearance of a reversible, amotivational syndrome in both adults and children treated with SSRIs [Selective Serotonin Reuptake Inhibitors, a category of supposedly antidepressant drugs]. Ultimately recognized by the prestigious *Textbook of Psychiatry*, the apathy syndrome refers to the delayed manifestation of behavioral changes in patients receiving serotonergic drugs, whose symptoms include apathy, flat affect, diminished motivation, and disinhibited actions. These features suggest a **frontal lobe syndrome** occurring eight weeks or more after the initiation of pharmacotherapy, or in many patients, after an increase in dose. One team of investigators corroborated the syndrome using neuroimaging studies in a 23-year-old patient who was treated with fluoxetine (Prozac) for obsessive compulsive disorder. In their research, the findings from SPECT [Single Photon Emission Computer Tomography] scans obtained before and after four months of daily medication revealed a 108% reduction in frontal lobe blood flow. These changes in blood flow paralleled reductions in motivation, attention, and memory, as well as decrements on neuropsychological tests designed to measure frontal lobe functions... Additional theories have been advanced as possible mechanisms of antidepressant-related violence. These include synergistic actions between alcohol and medication, whereby the disinhibiting effects of both substances hinder impulse control. Others have noted the potential for antidepressant therapy to provoke a wide variety of psychiatric symptoms, including mania, paranoia, hallucinations, panic attacks, or obsessive ruminations—all of which may contribute to suicidal and/or homicidal behaviors.

Psychiatrist Peter Breggin gives examples of people who became violent or suicidal in ways that were out-of-character for them in their unmedicated state in his book *Medication Madness—The Role of Psychiatric Drugs in Cases of Violence, Suicide, and Crime* (St. Martins Griffin 2009). Millions of people are prescribed psychiatric drugs that increase the risk they will become violent or suicidal, perhaps because of interference with the rapid eye movement or REM phase of sleep, perhaps by disabling the parts of the brain that would normally inhibit them from acting on angry or violent or suicidal impulses such as the frontal lobes. An eleven minute, twenty second YouTube video, "Psychiatric Drugs and Mass Shootings" includes many examples of psychiatric drugs seeming to cause homicide and suicide.

In her book *The Predictor Scale: Predicting & Understanding Behaviors* (Clifton Legacy Publishing 2013, p. 98), Faye Snyder, Psy.D., says "We have learned that some people react to anti-psychotics and anti-depressants in such a way that they become insanely psychotic, including acting out suicidal and homicidal fantasies."

Rather than correctly recognizing prescription psychiatric drugs as the problem, violence and suicide by people under the influence of psychiatric drugs have increased demands to "keep mentally ill people on their medication". Drug company advertising and biopsychiatric propaganda has been so successful, and fictional television crime shows and movies so misleading, that what in many cases *caused* the problem is thought of as the *cure*.

DRUG COMPANY ADVERTISING AND BIOPSYCHIATRIC PROPAGANDA HAS BEEN SO SUCCESSFUL, AND FICTIONAL TELEVISION CRIME SHOWS AND MOVIES SO MISLEADING, PSYCHIATRIC DRUGS THAT *CAUSE* VIOLENCE ARE THOUGHT TO *PREVENT* VIOLENCE

Today's perception of mental illness causing violence also confuses cause and effect in another way: People are not violent because they are mentally ill. They are called mentally ill because they are violent.

If psychiatric drugs are harmful, why do psychiatrists prescribe them?: First, they have been taught to do so. Second, they need to use medicine to establish and maintain their identity as medical doctors. As British psychiatrist Joanna Moncrieff says in her book *The Bitterest Pills—The Troubling Story of Antipsychotic Drugs* (Palgrave Macmillan 2013, p. 112), psychiatric drugs such as (so-called) antipsychotics are "central to the image that psychiatry was constructing of itself as a bona fide medial specialty." Third, using drugs insulates psychiatrists from competition from non-physician psycho-therapists who cannot write prescriptions. Fourth, by writing a prescription, psychiatrists (and others with prescribing authority) can justify their fee even if they have no understanding of what is happening to a person psychologically or emotionally and can offer no helpful counselling.

Psychiatric drugs are good for psychiatrists and other prescribers. They are bad for patients.

Seeing the harm done by psychiatric "medication", Dr. Douglas Smith helps people slowly withdraw from them. At the 2011 Empathic Therapy Conference he also said—

> One of the most pleasurable things about my work is seeing people come alive as they come off their [psychiatric] medicines. ... I mean, it's wonderful. ... To take a 28 year old

> young man that's been doped up, you know, on antipsychotics for a long time, and gradually work him off, and watch him come alive, it's *so* rewarding. It's one of the best things about what I do. ... It baffles me that psychologists are trying to get prescribing privileges.

The Worthlessness of FDA Approval

You are probably wondering how psychiatric drugs get approval from government agencies such as the U.S.A.'s Food & Drug Administration (FDA) if they are as harmful as indicated here. There are several reasons.

One reason is former drug company executives who seem to have more loyalty to their former employers than to the public hold high positions within the FDA.

Another reason is FDA officials who have never worked for a drug company acquiesce to drug company proposals in hopes of gaining favor and being hired at eye-popping salaries by the companies they (theoretically) regulate during their stint at the FDA. In the words of Princeton University economics professor Paul Krugman in a book published in 2012—

> Consider, for example, the revolving door, in which politicians and officials end up going to work for the industry they were supposed to oversee. That door has existed for a long time, but the salary you can get if the industry likes you is vastly higher than it used to be, which has to make the urge to accommodate the people on the other side of that door, to adopt positions that will make you an attractive hire in your postpolicy career, much stronger than it was thirty years ago. [*End this Depression Now!*, W.W.Norton & Co., p. 87]

In his book *Pharmocracy* (Praktikos Books 2011, p. 153), Life Extension Foundation Co-Founder William Faloon cites an Associated Press report saying "a record number of FDA employees are leaving the agency to go to work for pharmaceutical companies." He says "the FDA functions primarily to protect the financial interests of the pharmaceutical industry, not the public's health" (p. 152). In an article published in 2007, Marcia Angell, M.D., a senior lecturer at Harvard Medical School and former editor of the *New England Journal of Medicine*, says "The FDA now behaves as though the pharmaceutical industry is its user, not the public" ("Taking back the FDA", *Boston Globe*, February 26, 2007). Experts on FDA advisory panels are often simultaneously paid consultants for drug companies. According to Dr. Vernon Coleman, a British physician, "Governments say they can't find any doctors without conflict of interest to sit on committees assessing drugs" (*Do Doctors And Nurses Kill More People Than Cancer?*, European Medical Journal 2011, p. 34). Until this incestuous relationship between drug companies and the FDA is stopped by laws preventing anyone who has been employed by a drug company in recent years from serving at the FDA, and prohibiting FDA officials from accepting employment at drug companies for many years after leaving the FDA, and prohibiting experts on FDA advisory panels from accepting money from drug companies for many years before and after serving as consultants for the FDA, the FDA will probably continue to foster and protect the best interests of drug companies more than the best interests of the public.

Another reason for the approval of bad drugs is inadequate standards for drug approval. There must be two drug studies showing the drug being tested is better than a placebo (a pill with no active ingredients), with no limit on the number of studies that may be conducted in an effort to get the

required two favorable studies. It doesn't matter if the drug company must do 100 studies to come up with 2 that show the proposed new drug is better than placebo. The other 98 studies showing the drug being tested is no better than or worse than a placebo will not prevent approval of the drug. As Peter R. Breggin, M.D. & David Cohen, Ph.D., say in their book *Your Drug May Be Your Problem—How and Why to Stop Taking Psychiatric Medications* (DaCapo/Perseus 2007, p. 7): "In order to approve a drug, the FDA requires only two positive studies, but drug companies invariably have to conduct many clinical trials before they can come up with a couple of positive clinical trials." Psychiatrist Daniel Carlat, M.D., in a lecture available on YouTube.com, says "The FDA's bar for proof of effectiveness is one of the lowest bars you can imagine" ("Daniel Carlat—Unhinged: The Trouble With Psychiatry", uploaded September 11, 2012, at 24:19).

Many critics also allege that allowing drug companies to control the studies needed for FDA approval of the company's drugs allows the drug company to manipulate the results. For example, in his book *Overdosed America* (Harper Perennial 2008, p. xvii), described on the front cover of the paperback edition as "How the pharmaceutical Companies Are Corrupting Science, Misleading Doctors, and Threatening Your Health", John Abramson, M.D., of the clinical faculty of Harvard Medical School says "Rigging medical studies, misrepresenting research results published in even the most influential medical journals, and withholding the findings of whole studies that don't come out in a sponsor's favor have all become the accepted norm in commercially sponsored medical research." In the first edition of *Your Drug May Be Your Problem—How and Why to Stop Taking Psychiatric Drugs* (Perseus Books 1999, pp. 189-190), Drs. Breggin and Cohen say—

> But isn't psychiatry science? Isn't faith in psychiatry based on facts? On research? Can't we "trust in research"? The sad truth is that, in the field of psychiatry, it is impossible to "trust in research." Nearly all of the research in this field is paid for by drug companies and conducted by people who will "deliver" in the best way possible for those companies. ... Sadly, even well-informed people too often put their faith in psychiatry and psychiatric research. It is the same as putting their faith in a drug company.

In her book *Side Effects—A Prosecutor, a Whistleblower, and a Bestselling Antidepressant on Trial* (Algonquin Books 2008) Alison Bass shows how drug studies are deliberately falsified for the purpose of getting useless or harmful drugs approved and sold. She provides facts proving "that doctors who receive consulting or other personal income from drugmakers are more likely to report positive findings about a particular drug than researchers who don't receive money from the industry" and "psychiatry was the specialty with the highest number of doctors receiving payments from drug companies" (p. 224).

In his book *Saving Normal—An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (HarperCollins 2013, p. 212), psychiatrist Allen Frances says "The legal psychiatric drug industry has thrived through the aggressive spread of misinformation."

PEOPLE ARE NOT VIOLENT BECAUSE THEY ARE MENTALLY ILL. THEY ARE CALLED MENTALLY ILL BECAUSE THEY ARE VIOLENT.

Drug studies that are *not* paid for nor controlled by the drug company that is seeking approval for the drug are far more likely to show the drug is ineffective or harmful. The result is many drugs are approved for sale to the public that should not be. Government approval of a drug is little or no assurance of its effectiveness or safety. This is true for *all* drugs, not just psychiatric drugs.

Studies indicating psychiatric drugs are helpful are of dubious credibility not only because of dishonest drug company manipulation but also because of professional bias by psychiatrists employed in psychiatric drug testing. All or almost all psychiatric drugs are neurotoxic and for this reason cause symptoms and problems such as dry mouth, blurred vision, lightheadedness, dizziness, lethargy, difficulty thinking, menstrual irregularities, urinary retention, heart palpitations, and other consequences of neurological dysfunction. Psychiatrists deceptively call these "side-effects", even though they are the only real effects of today's psychiatric drugs. Placebos (or sugar pills) don't cause these problems. Since these symptoms (or their absence) are obvious to psychiatrists evaluating psychiatric drugs in supposedly double-blind drug trials, the drug trials aren't really double-blind, making it impossible to evaluate psychiatric drugs impartially. This allows professional bias to skew the results.

In the Introduction to his book *The Great Psychiatry Scam—One Shrink's Personal Journey* (Manitou Communications 2008, p. xii) psychiatrist Colin A. Ross, M.D., says "I will prove to you that over 90% of medication prescriptions for psychiatric inpatients have no scientific basis."

In her book *The Myth of the Chemical Cure—A Critique of Psychiatric Drug Treatment, Revised Edition* (Palgrave Macmillan 2009, p. 242) Joanna Moncrieff, M.B.B.S., M.Sc., MRCPsych, M.D., Senior Lecturer in the Department of Mental Health Sciences at University College London, U.K., says —

> In retrospect the physical treatments of the mid-20th century, such as insulin coma therapy and frontal lobotomy, stand revealed as dangerous and degrading procedures perpetrated on vulnerable people in the name of medical progress. In the same way the multiple and long-term drugging of modern day psychiatric patients will surely some day be acknowledged as a dangerous fraud.

Review of Psychiatry's "Medications" by Type

"ANTIDEPRESSANTS": *The Comprehensive Textbook of Psychiatry/IV*, published in 1985, says "The tricyclic-type drugs are the most effective class of anti-depressants" (Williams & Wilkins, p. 1520). But in his book *Overcoming Depression*, published in 1981, Dr. Andrew Stanway, a British physician, says "If anti-depressant drugs were really as effective as they are made out to be, surely hospital admission rates for depression would have fallen over the twenty years they've been available. Alas, this has not happened. ... Many trials have found that tricyclics are only marginally more effective than placebos, and some have even found that they are not as effective as dummy tablets" (Hamlyn Publishing Group, Ltd., p. 159-160). In his book *Psychiatric Drugs—Hazards to the Brain*, published in 1983, psychiatrist Peter Breggin, M.D., asserts "The most fundamental point to be made about the most frequently used major antidepressants is that they have no specifically antidepressant effect. Like the major tranquilizers [neuroleptics] to which they are so closely related, they are highly neurotoxic and brain disabling, and achieve their impact through the disruption of normal brain function. ... Only the 'clinical opinion' of drug advocates supports any antidepressant effect" of so-called antidepressant drugs (Springer Pub. Co., pp. 160 & 184). In another book published 30 years later, commenting not

only on the older supposed antidepressants available in 1983 such as tricyclics (TCA's) and monoamine oxidase inhibitors (MAOI's), but also the newer so-called antidepressants such as selective serotonin reuptake inhibitors (SSRI's) like Prozac, and serotonin and norepinephrine reuptake inhibitors (SNRI's), and with the benefit of another 30 years of research to back-up his claim, Dr. Breggin says "It is now abundantly clear that antidepressants in the long-term make people more depressed and often disabled" (*Psychiatric Drug Withdrawal*, Springer Publishing 2013, p. 137). In her book *The Myth of the Chemical Cure—A Critique of Psychiatric Drug Treatment* (Palgrave MacMillan 2009), Joanna Moncrieff, M.B.B.S., M.Sc., MRCPsych, M.D., Senior Lecturer in the Department of Mental Health Sciences at University College London, U.K., includes three chapters on supposedly antidepressant "medications" (pp. 118-173) including a chapter titled "Is There Such a Thing as an 'Antidepressant'?" in which she concludes there is not. Psychologist Irving Kirsch, Ph.D., makes a similar argument in his book *The Emperor's New Drugs—Exploding the Antidepressant Myth* (Basic Books 2010).

Psychiatry professor Richard Abrams, M.D., has said "Tricyclic Antidepressants...are minor chemical modifications of chlorpromazine [Thorazine] and were introduced as potential neuroleptics" (in: B. Wolman, *The Therapist's Handbook*, p. 31). Being neuroleptics (marketed as antidepressants), they have the same harmful effects and risks. In his book *Psychiatric Drugs—Hazards to the Brain*, Dr. Breggin calls the tricyclic antidepressants "Major Tranquilizers in Disguise" (p. 166). Psychiatrist Mark S. Gold, M.D., has said antidepressants can cause tardive dyskinesia (*The Good News About Depression*, Bantam 1986, p. 259). (See below for my critique of **neuroleptics**.)

Evidence so-called antidepressants make people feel worse, not better, is found in a study of Paxil, a best selling so-called antidepressant in the selective serotonin reuptake inhibitor (SSRI) category: It was found that "'suicide-related events' occurred almost four times more often in patients taking Paxil than in those taking a sugar pill" (Alison Bass, *Side Effects—A Prosecutor, a Whistleblower, and a Bestselling Antidepressant on Trial*, Algonquin Books 2008, p. 221).

It is because of evidence of this sort that on October 15, 2004, the U.S. Food & Drug Administration (FDA) began "requiring black box warnings on all thirty-two antidepressants currently on the market, old [tricyclic, MOAI] as well as new [SSRI, SNRI]", advising doctors and patients that supposedly antidepressant drugs make people more rather than less likely to commit suicide (*Id*., p. 218). Such a warning wouldn't be needed if so-called antidepressants had the favorable effects their manufacturers and biologically oriented psychiatrists claim.

"WARNING: SUICIDAL THOUGHTS AND BEHAVIORS

"Antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies. These studies did not show an increase in the risk of suicidal thoughts and behavior with antidepressant use in patients over age 24..."

(FDA required warning in advertisements for supposedly antidepressant "medications")

The FDA warning (above) indicating so-called antidepressants do not promote suicidal thoughts and behavior in "patients over age 24" is obvious nonsense that probably reflects either poor design of the studies or bias by researchers: Why would a drug promote suicidal thoughts and behavior in a 21 year old but not a 31 year old?

In *The Antidepressant Fact Book* (Perseus 2001, p. 107) psychiatrist Peter R. Breggin, M.D., says "There are so many potential hazards involved in taking SSRIs that no physician is capable of remembering all of them and no patient can be adequately informed about the dangers without spending days or weeks reviewing the subject in a medical library."

LITHIUM, the classic "**mood stabilizer**" is said to be helpful for people whose mood repeatedly changes from joyful to despondent and back again. Psychiatrists call this manic-depressive disorder or bipolar mood disorder. Lithium was first described as a psychiatric drug in 1949 by an Australian psychiatrist, John Cade. According to a psychiatric textbook: "While conducting animal experiments, Cade had somewhat incidentally noted that lithium made the animals lethargic, thus prompting him to administer this drug to several agitated psychiatric patients." The textbook describes this as "a pivotal moment in the history of psychopharmacology" (Harold I. Kaplan, M.D. & Benjamin J. Sadock, M.D., *Clinical Psychiatry*, Williams & Wilkins 1988, p. 342). Apparently, the fact that lithium induces lethargy is the only rationale for its use. A *supporter* of lithium as psychiatric therapy admits lithium causes "a mildly depressed, generally lethargic feeling". He calls it "the standard lethargy" caused by lithium (Roger Williams, "A Hasty Decision? Coping in the Aftermath of a Manic-Depressive Episode", *American Health* magazine, October 1991, p. 20). One of my cousins was diagnosed as manic-depressive and was given a prescription for lithium carbonate. He told me, years later, "Lithium insulated me from the highs but not from the lows." It should be no surprise a lethargy-inducing drug like lithium would have this effect. Amazingly, psychiatrists sometimes claim lithium wards off feelings of depression even though lethargy-inducing drugs like lithium (like most psychiatric drugs) *promote* feelings of despondency and unhappiness—even if they are called antidepressants.

Lithium is often described by health care scientists and physicians as "toxic" and as capable of inflicting bodily harm. According to the National Kidney Foundation—

> Lithium may cause problems with kidney health. ... The amount of kidney damage depends on how long you have been taking lithium. It is possible to reverse kidney damage caused by lithium early in treatment, but the damage may become permanent over time. [Lithium and Chronic Kidney Disease", kidney.org, accessed 7/21/2015]

Taking lithium makes people 30 times more likely to die (D. Ruschena, et al., "Choking deaths: the role of antipsychotic medication", *British Journal of Psychiatry*, Nov. 2003, Vol. 183, pp. 446-50, ncbi.nlm.nih.gov).

As with all biological treatment in psychiatry, lithium is administered as "treatment" for a "condition" or supposed mental illness for which there is no biological evidence.

MINOR TRANQUILIZERS (benzodiazepines): Included in this category are Ativan, Halcion, Klonopin, Librium, Valium and Xanax. Doctors who prescribe them say they have calming, anti-anxiety, panic-suppressing effects or are useful as sleeping pills. Anyone who believes these claims should read the article "High Anxiety" in the January 1993 *Consumer Reports* magazine, or read Chapter 11 in *Toxic Psychiatry* (St. Martin's Press 1991), by psychiatrist Peter Breggin, both of which allege the opposite is closer to the truth. British physician Vernon Coleman says "The benzodiazepines have caused infinitely more sorrow and despair than all illegal drugs put together" (benzo.org.uk, accessed January 15, 2015). Like all psychiatric drugs, the so-called minor tranquilizers don't cure anything but are merely brain-disabling drugs. In one clinical trial, 70 percent of persons taking Halcion "developed

memory loss, depression and paranoia" ("Halcion manufacturer Upjohn Co. defends controversial sleeping drug", *Miami Herald*, December 17, 1991, p. 13A). According to the February 17, 1992 *Newsweek*, "Four countries have banned the drug outright" (p. 58). "Halcion has been categorically banned in the Netherlands" according to William Styron in his book *Darkness Visible—A Memoir of Madness* (Random House 1990, p. 71). Britain banned Halcion in 1991 ("Sleeping pill Halcion banned by Britain", *Baltimore Sun*, October 3, 1991, baltimoresun.com). Yet Halcion remains legal in the U.S.A.

In his book *Saving Normal*, psychiatrist and psychiatry professor Allen Frances, M.D., says this about Xanax and the FDA (HarperCollins 2013, p. 216):

> Xanax has been more a wonder of profitability and longevity than a useful medication. Its therapeutic dosage is often high enough to be addicting, and its severe withdrawal anxiety is enough to keep patients hooked for life. Attempt at withdrawal may bring on severe panic or anxiety symptoms that are worse than the problems the patient started out with. Xanax is also a frequent collaborator with other prescription drugs and alcohol in iatrogenic overdoses and deaths. It has little role, if any, in the proper practice of medicine. If there was a proper war against prescription drug misuse, Xanax would be an early casualty—but under current policies the FDA has no mechanism to rein in drugs that do more harm than good.

In his book *Toxic Psychiatry*, psychiatrist Peter Breggin, speaking of the minor tranquilizers, says "As with most psychiatric drugs, the use of the medication eventually causes an increase of the very symptoms that the drug is supposed to ameliorate" (p. 246).

David Knott, a physician at the University of Tennessee, in 1976 warned: "I am very convinced that Valium, Librium and other drugs of that class cause damage to the brain. I have seen damage to the cerebral cortex that I believe is due to the use of these drugs, and I am beginning to wonder if the damage is permanent" (quoted in Robert Whitaker, *Anatomy of an Epidemic*, Crown Publishers 2010, p. 137).

ADHD DRUGS: Like all psychiatric "medications", drugs for attention deficit hyperactivity "disorder" (ADHD) are given for a supposed illness or condition nobody can show exists in a biological sense. Diagnosis is subjective. No laboratory test for ADHD exists. "There is no convincing evidence for either short- or long-term improvement in cognitive ability or academic performance" in those taking drugs for ADHD (Peter R. Breggin, M.D., *Brain-Disabling Treatments in Psychiatry, Second Edition*, Springer Publishing Co., 2008, p. 285). The harmful effects of drugs that supposedly treat ADHD include psychosis, mania, aggression, suicide, cardiovascular risks including heart attack, stroke, sudden death, brain atrophy, destruction of brain cells, permanent suppression of height and temporary suppression of weight (*Id.*, pp. 296, 299, 307, 311, 315).

NEUROLEPTICS: Even as harmful as psychiatry's (so-called) antidepressants and lithium and (so-called) antianxiety agents (or minor tranquilizers) and ADHD drugs are, they are nowhere near as damaging as the neuroleptics, now most often (although incorrectly) called "antipsychotic" drugs. "Neuroleptic" means nerve-seizing. At one time these drugs were called "**major tranquilizers**", but over time the myth that they are anti-psychosis developed. Included in this category are "older" or "typical" neuroleptics such as Thorazine (chlorpromazine), Mellaril, Prolixin (fluphenazine), Compazine, Stelazine, and Haldol (haloperidol) and "newer" or "atypical" or "second generation"

neuroleptics such as Abilify, Clozaril, Geodon, Invega, Latuda, Risperdal, Seroquel, and Zyprexa. Contrary to the often-repeated claim the newer or so-called atypical or second-generation neuroleptics are less likely than "older" or "typical" neuroleptics to cause neurological damage manifested by movement disorders, sometimes called "extrapyramidal side effects", such as tardive dyskinesia, dystonia, and akathisia, the National Institute of Mental Health (NIMH) *Clinical Antipsychotic Trials of Intervention Effectiveness* (CATIE) study in 2005 found that "Contrary to expectations, movement side effects (rigidity, stiff movements, tremor, and muscle restlessness [dyskinesia, dystonia, and akathisia]) primarily associated with the older medications were not seen more frequently with perphenazine than with the newer drugs", perphenazine being one of the older or "typical" neuroleptics chosen because "perphenazine is an effective older antipsychotic that is less likely to produce EPS [extrapyramidal side effects]" than most "typical" or first-generation neuroleptics. This study found that "taken as a whole, the newer medications ["atypical" neuroleptics] have no substantial advantage over the older medication [perphenazine, the "typical" neuroleptic] used in this study" ("Questions and Answers About the NIMH Clinical Antipsychotic Trials of Intervention Effectiveness Study (CATIE) — Phase 1 Results", September 2005, available at www.nimh.nih.gov).

In terms of their psychological effects, these so-called antipsychotics, or major tranquilizers, cause misery—not tranquility. They reduce a person's ability to think and act. By disabling people, they can stop almost any thinking or behavior the "therapist" wants to stop. But this is simply disabling people, not therapy. The drug temporarily disables or permanently destroys good aspects of a person's personality as much as bad. In the words of Dr. Joanna Moncrieff, a British psychiatrist and Senior Lecturer in Mental Health Sciences at the University College, London, the neuroleptic or supposedly antipsychotic drugs are "not selective. They're not simply suppressing the psychosis. They're suppressing everything" ("Joanna Moncrieff—The Myth of the Chemical Cure—the Politics of Psychiatric Drug Treatment", February 25, 2013, YouTube.com, at 28:35).

Whether and to what extent the disability imposed by the drug can be removed by discontinuing the drug depends on how long the drug is given and at how great a dose. The neuroleptic, so-called major tranquilizer/"antipsychotic" drugs damage the brain more clearly, severely, and permanently than any others used in psychiatry. In his book *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (Perseus 2002, p. 191) journalist Robert Whitaker says "Neuroleptics have been found to cause a dizzying array of pathological changes in the brain." Joyce G. Small, M.D., and Iver F. Small, M.D., both Professors of Psychiatry at Indiana University, criticize psychiatrists who use "psychoactive medications that are known to have neurotoxic effects", and speak of "the increasing recognition of long-lasting and sometimes irreversible impairments in brain function induced by neuroleptic drugs. In this instance the evidence of brain damage is not subtle, but is grossly obvious even to the casual observer!" (*Behavioral and Brain Sciences*, March 1984, Vol. 7, p. 34). According to Conrad M. Swartz, Ph.D., M.D., Professor of Psychiatry at Chicago Medical School, "While neuroleptics relieve psychotic anxiety, their tranquilization blunts fine details of personality, including initiative, emotional reactivity, enthusiasm, sexiness, alertness, and insight. ... This is in addition to side effects, usually involuntary movements which can be permanent and are hence evidence of brain damage" (*Behavioral and Brain Sciences*, March 1984, Vol. 7, pp. 37-38).

A report in the *Mental and Physical Disability Law Reporter* indicates some courts in the United States have considered involuntary administration of neuroleptic (so-called major tranquilizer or

antipsychotic) drugs to involve First Amendment rights "Because ... antipsychotic drugs have the capacity to severely and *even permanently* affect an individuals' ability to think and communicate" ("Involuntary medication claims go forward", January-February 1985, p. 26, emphasis added).

In a concurring opinion in *Rennie v. Klein*, 720 F.2d 266 (3rd Cir 1983), three U.S. Court of Appeals judges (Weiss, et al.) said this:

> Unlike the temporary and predictable effects of bodily restraints, the permanent side effects of antipsychotic drugs induce conditions that cannot be corrected simply by cessation of the regimen. The permanency of these effects is analogous to that resulting from such radical surgical procedures as a pre-frontal lobotomy.

For this reason, neuroleptic or "antipsychotic" drug use, especially when administered for a long time, has been called a "chemical lobotomy."

In *Molecules of the Mind: The Brave New Science of Molecular Psychology*, University of Maryland journalism professor Jon Franklin says "This era coincided with an increasing awareness that the neuroleptics not only did not cure schizophrenia—they actually caused damage to the brain." (Dell Pub. Co. 1987, p. 103). Psychiatry professor Richard Abrams, M.D., has acknowledged, "Tardive dyskinesia has now been reported to occur after only brief courses of neuroleptic drug therapy" (in: Benjamin B. Wolman (editor), *The Therapist's Handbook: Treatment Methods of Mental Disorders*, Van Nostrand Reinhold Co. 1976, p. 25). In his book *The New Psychiatry*, published in 1985, Columbia University psychiatry professor Jerrold S. Maxmen, M.D., says "The best way to avoid tardive dyskinesia is to avoid antipsychotic drugs altogether. Except for treating schizophrenia, they should never be used for more than two or three consecutive months. What's criminal is that all too many patients receive antipsychotics who shouldn't" (Mentor, pp. 155-156). In my opinion, Dr. Maxmen doesn't go far enough: His characterization of administration of neuroleptic (so-called antipsychotic or ma#or tranquilizer drugs) as "criminal" is accurate for all people, including those called schizophrenic, even when the drugs aren't given long enough for the resulting brain damage to show up as tardive dyskinesia.

In *Psychiatric Drugs—Hazards to the Brain* (Springer Pub. Co. 1983, pp. 70, 107, 135, 146) psychiatrist Peter Breggin, M.D., says this:

> The major tranquilizers [neuroleptics] are highly toxic drugs; they are poisonous to various organs of the body. They are especially potent neurotoxins, and frequently produce permanent damage to the brain. ...tardive dyskinesia can develop in low-dose, short-term usage... the dementia [loss of higher mental functions] associated with the tardive dyskinesia is not usually reversible. ... Seldom have I felt more saddened or more dismayed than by psychiatry's neglect of the evidence that it is causing irreversible lobotomy effects, psychosis, and dementia in millions of patients as a result of treatment with the major tranquilizers.

POWER TO DRUG A PERSON BY FORCE
IS POWER TO DISABLE OR KILL HIM

In the same book Dr. Breggin, says that by using drugs that cause brain damage, "Psychiatry has unleashed an epidemic of neurological disease on the world" one which "reaches 1 million to 2 million persons a year" (pp. 109 & 108). In *Brain-Disabling Treatments in Psychiatry, Second Edition* (Springer Pub. Co. 2008, p. 62), Dr. Breggin says "The best approach to neuroleptics, in this author's opinion, is never to use them."

In *Brain Disabling Treatments in Psychiatry, Second Edition* (Springer Publishing Co. 2008, p. 112) Dr. Breggin says "prescribing physicians cannot fully inform patients about the risks associated with neuroleptics because no one except the most self-destructive patient would knowingly take such toxic drugs."

Critics of psychiatry say reform will not come from within psychiatry but must come from outside psychiatry, such as from the public, legislation, or judicial decisions. The author of the Preface of a book by four physicians (William E. Fann, M.D., et al., *Tardive Dyskinesia: Research & Treatment*, SP Medical & Scientific 1980) implicitly supports this view:

> In the late 1960s I summarized the literature on tardive dyskinesia ... The majority of psychiatrists either ignored the existence of the problem or made futile efforts to prove that these motor abnormalities were clinically insignificant or unrelated to drug therapy. In the meantime the number of patients affected by tardive dyskinesia increased and the symptoms became worse in those already afflicted by this condition. ... there are few investigators or clinicians who still have doubts about the iatrogenic [physician caused] nature of tardive dyskinesia. ... It is evident that the more one learns about the toxic effects of neuroleptics on the central nervous system, the more one sees an urgent need to modify our current practices of drug use. It is unfortunate that many practitioners continue to prescribe psychotropics in excessive amounts, and that a considerable number of mental institutions have not yet developed a policy regarding the management and prevention of tardive dyskinesia. If this book, which reflects the opinions of the experts in this field, can make a dent in the complacency of many psychiatrists, it will be no small accomplishment." [Preface to: William E. Fann, M.D., et al., *Tardive Dyskinesia: Research & Treatment*, SP Medical & Scientific 1980]

These harmful so-called antipsychotic drugs are forced upon patients and prisoners despite being ineffective for their supposed purpose. In the second edition of their book *Your Drug May Be Your Problem—How and Why to Stop Taking Psychiatric Medications* (DaCapo/Perseus 2007, p. 101), Drs. Breggin and Cohen say "Contrary to claims, neuroleptics have no specific effects on irrational ideas (delusions) or perceptions (hallucinations)." Similarly, in his book *Saving Normal—An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*, (Harper Collins 2013, p. 198, 199), psychiatrist Allen Frances, M.D., says people thought psychotic are given "atypical antipsychotic medications that have no proven efficacy. And most damning, these drugs have extremely dangerous complications." On the next page he says, "there is no proof whatever that antipsychotic medications are effective in preventing psychotic episodes."

Why, therefore, are these drugs called "anti-psychotic"?

In some studies, so-called antipsychotic or neuroleptic drugs have been found to *cause* rather than suppress psychosis. For example, in the U.S. Food & Drug Administrations (FDA's) "Focused Safety Review of Invega, March 14, 2013"—Invega being a so-called "atypical" supposedly anti-psychotic "medication"—it was found that "the most common serious AE [

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vent]" of taking Invega "was schizophrenia" ("Pharmaceutical Companies, the Largest Legal Settlements in US History and Illegal Marketing of Antipsychotic Drugs", by Attorney Stephen Sheller, at Dr. Peter Breggin's 2013 Empathic Therapy Conference, Syracuse, New York). Schizophrenia is generally considered a type of psychosis.

Calling drugs that *cause* psychosis "anti-psychotic" is typical of the misleading use of words in psychiatry. Psychiatry is a field in which words *invert the truth*: Drugs that make people more depressed are called "antidepressant". Drugs that make people more anxious, particularly during withdrawal, are called "anti-anxiety" or "anxiolytic". Toxic substances that cause disease are called "medication".

An article in a 2007 issue of *Neuropsychopharmacology* by scientists in the departments of psychiatry, statistics, and neuroscience at the University of Pittsburgh (Pennsylvania) said "Both *in vivo* [during life] and post-mortem investigations have demonstrated smaller volumes of the whole brain and of certain brain regions in individuals with schizophrenia. It is unclear to what degree such smaller volumes are due to the illness or to the effects of antipsychotic treatment." So researchers studied the effect of supposedly antipsychotic or neuroleptic drugs on monkeys, since only humans, not monkeys, are thought to be capable of having schizophrenia. They found "chronic exposure of macaque monkeys to haloperidol [Haldol, a "typical" antipsychotic] or olanzapine [Zyprexa, an "atypical" antipsychotic], at doses producing [blood] plasma levels in the therapeutic range in schizophrenia subjects, was associated with significantly smaller total brain weight and volume, including an 11.8-15.2% smaller gray matter volume in the left parietal lobe." The study suggests reduced brain size in individuals who take neuroleptic/antipsychotic "medications" are due to "antipsychotic"/neuroleptic "medications", not "schizophrenia" (Glenn T. Konopaske, et al., "Effect of Chronic Exposure to Antipsychotic Medication on Cell Numbers in the Parietal Cortex of Macaque Monkeys", *Neuropsychopharmacology*, Vol. 32, pp. 1216-1223).

The brain-damaging effect of supposedly antipsychotic drugs was also confirmed in an article in the February 2011 *Archives of General Psychiatry* that reported on a study of "Two hundred eleven patients with schizophrenia who underwent repeated neuroimaging". The study found "smaller brain tissue volumes and larger cerebrospinal fluid volumes. Greater intensity of antipsychotic [neuroleptic] treatment was associated with indicators of generalized and specific brain tissue reduction... More antipsychotic treatment was associated with smaller gray matter volumes. Progressive decrement in white matter volume was most evident among patients who received more antipsychotic treatment" (Beng-Choon Ho, MRCPsych; Nancy C. Andreasen, M.D., Ph.D., Steven Ziebell, B.S., Ronald Pierson, M.S., Vincent Magnotta, Ph.D., "Long-term Antipsychotic Treatment and Brain Volumes: A Longitudinal Study of First-Episode Schizophrenia", Vol. 68, No. 2, pp. 128-137).

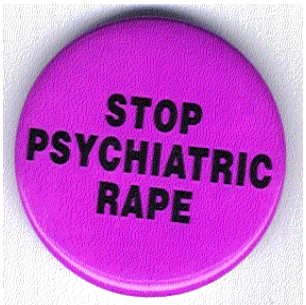
The most severe side-effect of neuroleptics is *death* from neuroleptic malignant syndrome and other neurological malfunction caused by these "medications" such as cardiac arrhythmia (uncoordinated heartbeat). In *Brain-Disabling Treatments in Psychiatry, Second Edition* (Springer Publishing Co. 2008, p. 83), Dr. Breggin cites Gill, et al., in 2007 finding "Both the older and the atypical neuroleptics

were associated with in increased risk of death at all assessment times, including 180 days, by a factor of 1.31-1.55 times."

Why do the so-called patients accept such "medication"? Sometimes they do so because of ignorance about the neurological damage and risk of death to which they are subjecting themselves by following their physician's or psychiatrist's advice to take the "medication". But much if not most of the time, neuroleptic drugs are literally *forced* into the bodies of the "patients" against their will. In his book *Psychiatric Drugs—Hazards to the Brain*, psychiatrist Peter Breggin, M.D., says "Time and again in my clinical experience I have witnessed patients driven to extreme anguish and outrage by having major tranquilizers forced on them. ... The problem is so great in routine hospital practice that a large percentage of patients have to be threatened with forced intramuscular injection before they will take the drugs" (p. 45).

Psychiatric Rape

Not only is this a kind of tyranny, but the forced administration of a psychiatric drug can be compared, physically and morally, with rape. Compare sexual rape and involuntarily administration of a psychiatric drug injected intramuscularly into the buttocks, which is a part of the anatomy where the injection is often given: In both sexual rape and involuntary administration of a psychiatric drug, force is used. In both cases, the victim's pants are pulled down. In both cases, a tube is inserted into the victim's body against her (or his) will. In the case of sexual rape, the tube is a penis. In the case of what could be called psychiatric rape, the tube is a hypodermic needle. In both cases, a fluid is injected into the victim's body against her or his will. In both cases it is or may be in (or near) the derriere. In the case of sexual rape the fluid is semen. In the case of psychiatric rape, the fluid is Thorazine, Prolixin or some other brain-disabling drug. The fact of bodily invasion is similar in both cases if not (for reasons I'll explain) actually worse in the case of psychiatric rape. So is the sense of outrage in the mind of the victim of each type of assault. (Victims of electroshock or ECT which was forced on them typically feel the same way.) Some who are not "hospitalized" (that is, imprisoned) are required to report to a doctor's office for injections of a long-acting neuroleptic like Prolixin every two weeks by the threat of imprisonment ("hospitalization") and forcible injection of the drug if they don't comply.



Why is psychiatric rape worse than sexual rape? As brain surgeon I. S. Cooper, M.D., says in his autobiography: "It is your brain that sees, feels, thinks, commands, responds. *You are your brain. It is you.* Transplanted into another carrier, another body, your brain would supply it with your memories, your thoughts, your emotions. It would still be you. The new body would be your container. It would carry you around. *Your brain is you" (The Vital Probe: My Life as a Brain Surgeon,* W.W.Norton & Co. 1982, p. 50, emphasis in original). *The most essential and most intimate part of you is not what is*

between your legs but what is between your ears. An assault on a person's brain such as involuntary administration of a brain-disabling or brain-damaging "treatment" (such as a psychoactive drug or electroshock or psychosurgery) is a more intimate and morally speaking more horrible crime than sexual rape. Psychiatric rape is in moral terms a worse crime than sexual rape for another reason, also: The involuntary administration of psychiatry's biological "therapies" cause *permanent* impairment of brain function. In contrast, women usually are still fully sexually functional after being sexually raped. They suffer psychological harm, but so do the victims of psychiatric assault. I hope I will not be understood as belittling the trauma or wrongness of sexual rape if I point out that I have counselled sexually raped women in my law practice and that each of the half-dozen or so women I have known who have been sexually raped have gone on to have apparently normal sexual relationships, and in most cases marriages and families. In contrast, the brains of people subjected to psychiatric assault often are not as fully functional because of the *physical, biological* harm done by the "treatment".

AN ASSAULT ON A PERSON'S BRAIN, SUCH AS INVOLUNTARY ADMINISTRATION OF A PSYCHIATRIC DRUG, IS A MORE INTIMATE ASSAULT THAN SEXUAL RAPE

In his interview with Dr. Joanna Moncrieff on 10/23/2013, psychiatrist Peter Breggin said this about the so-called antipsychotic, or neuroleptic "medications":

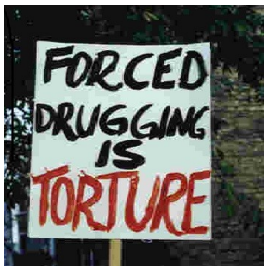
> I feel more strongly, that we *do* know where we stand, that they are toxins. They ruin brain function, ultimately. They're shortening lifespans, in some studies indicating up to *twenty years* being lopped off peoples' lives on these drugs long term. I feel more strongly that in fact they're just a disaster, that we'd do better without them, and that <u>in a sane society they'd be illegal</u>. ... The [psychiatric] profession just refuses to look at this because...it threatens it's very core, its very identity. It's like taking a hammer away from a carpenter, maybe even the nails, too. [Dr. Peter Breggin Hour at 42:30, underline added]

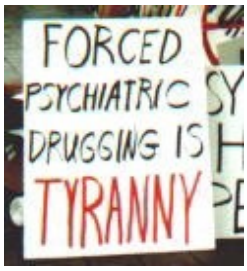
Similarly, a year later in 2014 British psychiatrist Joanna Moncrieff said "I've found that the psychiatric establishment really does not want to engage in discussion of this issue of what its drugs are actually doing, possibly because that is just too dangerous and too difficult to rebut" ("Madness, Drugs and Capitalism: an Exploration by Dr. Joanna Moncrieff" YouTube.com, November 18, 2014, at 39:45).

A report by the National Association of State Mental Health Program Directors, "Morbidity and Mortality in People with Serious Mental Illness", in October 2006, states in bold italics, ***"People with serious mental illness (SMI) die, on average, 25 years earlier than the general population. State studies document recent increases in death rates over those previously reported***" (p. 5). These increased death rates correspond with the advent and increase in use of psychiatric drugs. In *Brain-Disabling Treatments in Psychiatry, Second Edition*, psychiatrist Peter Breggin says "Until the advent of neuroleptic drugs, it was observed that patients diagnosed with schizophrenia lived normal life spans" (p. 82). Now that people thought to have serious mental illness such as "schizophrenia" are being drugged, they are dying 25 years sooner than average.

Psychiatrists continue damaging and killing "patients" with "medications" rather than admit psychiatric drugs are harmful—and lethal if taken long enough—because it is difficult for them to

acknowledge the harm they have inflicted and continue to inflict on their patients, and because widespread recognition of what psychiatric drugs really do would bring about the end of psychiatry as a profession.





Since psychiatric drugs are not effective and have horrible, even lethal, effects on health, why are legislatures and courts authorizing their *involuntary* administration? The answer is legislators and judges sincerely believe mental illness (a) exists, and (b) is caused by biological abnormalities that can corrected by drugs. They are, in other words, misinformed. Instead of authorizing involuntary administration of psychiatric drugs, lawmakers and judges should be *prohibiting* their use (with the exception of attempts at phased withdrawal for people who are already taking them).

On a TV talk show in 1990, psychoanalyst Jeffrey Masson, Ph.D., said he hopes those responsible for harmful psychiatric "therapies" will one day face "Nürnburg trials" (*Geraldo*, Nov. 30, 1990).

Use in Nursing Homes

These very same brain-damaging (so-called) neuroleptic/antipsychotic drugs are routinely administered —involuntarily—to mentally healthy old people in nursing homes in the United States. According to an article in the September/October 1991 issue of *In-Health* magazine, "In nursing homes, antipsychotics are used on anywhere from 21 to 44 percent of the institutionalized elderly... half of the antipsychotics prescribed for nursing home residents could not be explained by the diagnosis in the patient's chart. Researchers suspect the drugs are commonly used by such institutions as chemical straightjackets—a means of pacifying unruly patients" (p. 28). I know of two examples of feeble old men in nursing homes who were barely able to get out of their wheelchairs who were given a neuroleptic/antipsychotic drug. One complained because he was strapped into a wheelchair to prevent his attempts to walk with his cane. The other was strapped into his bed at night to prevent him from getting up and falling when going to the bathroom, necessitating defecating in his bed. Both were so physically disabled they posed no danger to anyone. But both dared complain bitterly about how they were mistreated. In both cases the nursing home staffs responded to these complaints with injections of Haldol—mentally disabling these men, thereby making it impossible for them to complain.

Theory of Action: Unknown

Despite various unverified theories and claims, psychiatrists don't know how the drugs they use work biologically. In the words of Columbia University psychiatry professor Jerrold S. Maxmen, M.D.: "How psychotropic drugs work is not clear" (*The New Psychiatry*, Mentor 1985, p. 143). According to the Psychopharmacology Institute web site (psychopharmacologyinstitute.com ©2015, accessed Feb. 20, 2015), edited by Flavio Guzman, M.D., a psychiatrist and Adjunct Professor of Pharmacology and Neurosciences at the University of Mendoza, "The exact mechanism of action of antipsychotic drugs is

unknown."

All of today's commonly used psychiatric drugs suppress brain and other nervous system function, even basic functions such as heartbeat and motor control. The result is deaths from cardiac irregularities in persons taking supposedly antipsychotic drugs, and iatrogenic (physician-caused) neurological diseases such as tardive dyskinesia, dystonia, akathisia, and drug-induced dementia.

None of today's psychiatric drugs have the specificity (e.g., for depression or anxiety or psychosis) that is often claimed for them. In *The Truth About the Drug Companies* (Random House 2005, p. 82), Marcia Angell, M.D., says "In 1987, the FDA approved Prozac for the treatment of depression; in 1994, for the treatment of obsessive-compulsive disorder; in 1996, for bulimia". In his book *Blaming the Brain—The Truth About Drugs and Mental Health* (Free Press 1998, p. 105), Elliot Valenstein, Ph.D., Professor Emeritus of Psychology and Neuroscience at the University of Michigan, says—

> Psychiatrists prescribe Prozac and the other selective serotonin reuptake inhibitors not only for depression, but also for obsessive-compulsive disorders, panic disorders, various food-related problems (including both anorexia and bulimia), premenstrual dysphoric syndrome (PMS), attention-deficit/hyperactivity disorder (ADHD), borderline personality disorder, drug and alcohol addiction, migraine headaches, social phobia, arthritis, autism, and behavioral and emotional problems in children, among many other conditions.

A February 2011 article in *Pharmacoepidemiology and Drug Safety* ("Increasing off-label use of antipsychotic medications in the United States, 1995-2008", Vol. 20, Issue 2, pp. 177-184) by Caleb Alexander, M.D., Assistant Professor of Medicine at the University of Chicago, and Randall Stafford, M.D., Ph.D., Associate Professor of Medicine at Stanford Prevention Research Center, et al., says "Although approved initially for schizophrenia, antipsychotic medications also are used for numerous other conditions, including other psychoses, bipolar disorder, delirium, depression, personality disorders, dementia, and autism." In a lecture at the National Educational Alliance—Borderline Personality Disorder (BPD) conference in Atlanta, Georgia on November 4, 2011, psychiatrist Kenneth Silk, M.D., said drugs as diverse as SSRI antidepressants, mood stabilizers, and both typical and atypical antipsychotics have been used as "treatment" for BPD ("Medication: The Positives and the Negatives—Kenneth Silk, MD", YouTube.com at 39:55-41:10). In *We've Got Issues—Children and Parents in the Age of Medication* (Riverhead Books 2010, p. 171), Judith Warner recalls that "In the late 1970s ... antianxiety meds were being given—rightly or wrongly—as treatment for a wide array of problems, including depression." Why would an "anti-anxiety" drug be used for depression if psychiatric drugs have any specificity rather than a general disabling effect? Reading or hearing such comments from psychiatrists and other mental health professionals and other observers, or paying attention to advertising for psychiatric drugs and seeing some initially advertised as antipsychotic later advertised as useful against depression (e.g., Abilify), or supposed antidepressants advertised as effective in quitting smoking or suppressing obsessive-compulsive disorder or other problems, it eventually becomes difficult to avoid the conclusion that *any and every psychiatric drug is used to treat any and every supposed psychiatric problem*. All psychiatric drugs are mentally disabling generally and therefore can be used to reduce *anything* in human thinking or behavior (both good and bad). So why are some called "antianxiety", and others "antipsychotic" or "antidepressant" or "mood stabilizers"? The answer is *salesmanship*. Claims that any particular type of psychiatric drug is specifically effective against any specific type of psychiatric problem is salesmanship, not science.

How Psychiatrists Decide Which Drug to Prescribe: Guesswork

According to psychiatrist Daniel J. Carlat, M.D., in his book *Unhinged—The Trouble With Psychiatry* (Free Press 2010, pp. 83, 84, 86)—

> The fact is that psychopharmacology is primarily trial and error, a kind of muddling through different candidate medications until we hit on one that works. ...we rely largely on intangible factors to make these decisions. ... What to do in a case like this, in which the first drug loses its effectiveness? The process of selecting a second agent is guesswork. ... Such is modern psychopharmacology. Guided purely by symptoms, we try different drugs, with no real conception of what we are trying to fix, or of how the drugs are working. [underline added]

In their book *Mad Science—Psychiatric Coercion, Diagnosis, and Drugs* (Kirk, et al., Transaction Publishers 2013), three social work professors reach a similar conclusion:

> Also, together we've amassed over seventy-five years of teaching mental health courses in graduate schools of social work to thousands of students and professionals ... It seems to us, on the other hand, that clinical psychopharmacology—the medically sanctioned use of psychoactive drugs for the treatment of medically legitimated distress and misbehavior (termed *mental disorders*)—has always been a pseudoscientific enterprise. ... nearly all psychotropic drug classes end up prescribed for all groups of disorders ... there are no demonstrated biological anomalies for any drug to target to "cure" the mental disorders in question. ... no radical innovation based on genetic knowledge is leading the way to find any *curative* compounds in psychiatry, because there is simply no idea about what specific part of the body, if any, need fixing when people suffer or misbehave. ... Psychoactive drugs, let us note, are prescribed in the absence of demonstrated physical pathology. [pp. 301, 250, 262, 251, 254, 255, italics in original]

According to Jack M. Gorman, M.D., in his book *The Essential Guide to Psychiatric Drugs, 4th Edition* (St. Martin's/Griffin 2007, p. 6), psychiatrists decide which drug to prescribe on the basis of "clinical lore, experience, and intuition" rather than bona-fide science.

This could be called "The Myth of Psychopharmacology": "...ology" means *knowledge*. For example, "Nephr*ology*" is knowledge about kidneys, and "psych*ology*" is knowledge of the psyche, or mind. But in the case of "psychopharmacology", the knowledge is absent. "Psychopharmacology", in other words, is a form of quackery.

The haphazard way therapists chose which psychiatric drug to prescribe is also admitted, at least tacitly, in the *Handbook of Clinical Psychopharmacology for Therapists, Sixth Edition*, (John D. Preston, Psy.D., et al., New Harbinger Publications 2010, pp.179-180), written by a psychologist, a psychiatrist, and a pharmacist. For depression, their advice about choosing a supposedly antidepressant "medication" is mostly about avoiding so-called side-effects. They admit "No antidepressant has been proven consistently superior to another" (p. 170), and "Despite our knowledge of some of the important mechanisms of action of these medications, we still do not really know how they relieve depression" (p. 169). They say "Whichever antidepressant is chosen first, the question of what to try if the first one doesn't work may arise" (p. 179). They suggest "switching *classes* of antidepressants (i.e., if first treated with an SSRI [selective serotonin reuptake inhibitor], switch to a norepinephrine or dopamine reuptake inhibitor, such as bupropion) versus switching *within* class (i.e., from one SSRI to another

SSRI)" (pp. 179-180, italics theirs).

There is no rational way for a drug prescriber to know one so-called antidepressant will be more effective than another, because there are neither biological nor psychological tests to indicate, for example, that one patient suffers from a type of depression that will be relieved by a tricyclic antidepressant but not a SSRI, another patient a type of depression that will be relieved by a SSRI and not a tricyclic, and another patient a type of depression that will be relieved by a SNRI (serotonin and norepinephrine reuptake inhibitor) but not a tricyclic nor SSRI, and another patient a type of depression that will be relieved only by a MAOI (monoamine oxidase inhibitor). The situation is the same for all psychiatric drugs, such as supposedly antipsychotic and supposedly anti-anxiety drugs. As Dr. Gorman says, it's all "clinical lore, experience, and intuition". That's guesswork, not science.

Like Taking Insulin for Diabetes?

It is often asserted that taking a psychiatric drug is like taking insulin for diabetes. Although psychiatric drugs are taken continuously, as is insulin, it's an absurd analogy. Diabetes is a disease with a known physical cause. No physical cause has been found for any of today's so-called mental illnesses. The mode of action of insulin is known: It is a hormone that instructs or causes cells to uptake dietary glucose (sugar). In contrast, the modes of action of psychiatry's drugs are unknown—although even advocates of psychiatric drugs as well as critics theorize they prevent normal brain functioning by blocking neuroreceptors in the brain. If this theory is correct it is another contrast between taking insulin and taking a psychiatric drug: Insulin *restores* a normal biological function, namely, normal glucose (or sugar) metabolism. Psychiatric drugs *interfere* with a normal biological function, namely, normal neuroreceptor functioning. Insulin is a hormone that is found naturally in the body. Psychiatry's drugs are not normally found in the body. Insulin gives a diabetic's body a capability it would not have in the absence of insulin, namely, the ability to metabolize dietary sugar normally. Psychiatric drugs have an opposite kind of effect: They take away (mental) capabilities the person would have in the absence of the drug. Insulin affects the body rather than the mind. Psychiatric drugs disable the brain and hence the mind, the mind being the essence of the real self.

There Are No Justifiable Uses of Psychiatric Drugs

In the final analysis, "there are no justifiable uses of psychiatric drugs" (Dr. Joanna Moncrieff, *The Myth of the Chemical Cure—A Critique of Psychiatric Drug Treatment, Revised Edition*, Palgrave Macmillan 2009, p. 15, summarizing the view of Dr. Peter Breggin, which she says "usefully highlights the general character of psychotropic drugs.") I believe adults should have the right to use whatever drugs they want. However, the use of psychiatric drugs *by licensed professionals* is an example of medical professionals failing to adequately regulate themselves, and the failure of state legislatures, Congress, and regulatory agencies like the USA's Food and Drug Administration (FDA) to protect the public. Peter C. Gøtzsche, a physician specializing in internal medicine, and professor of Clinical Research Design and Analysis at the University of Copenhagen, devotes two chapters to psychiatric drugs in his book *Deadly Medicines and Organized Crime — How Big Pharma Has Corrupted Healthcare* (Radcliffe 2013). He closes the second of these two chapters with the following words, which he indents and italicizes for emphasis, and with which I will end this essay:

Our citizens would be far better off if we removed all the psychotropic drugs from the market, as doctors are unable to handle them. It is inescapable that their availability creates more harm than good. [p. 233]

Caution: Stopping taking psychiatric drugs *abruptly* can cause severe, even life-threatening, withdrawal problems. For advice about how to withdraw from psychiatric drugs, see *Psychiatric Drug Withdrawal—A Guide for Prescribers, Therapists, Patients, and Their Families* (Springer Publishing 2013) by psychiatrist Peter R. Breggin, M.D., or *Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications* (Da Capo Press 2007) by Dr. Breggin and clinical social work professor David Cohen.

Recommended Reading

Books

John Abramson, M.D., *Overdosed America—The Broken Promise of American Medicine* (Harper Perennial 2008)

Marcia Angell, M.D., *The Truth About Drug Companies—How They Deceive Us and What To Do About It* (Random House 2005)

Alison Bass, *Side Effects—A Prosecutor, A Whistleblower, and a Bestselling Antidepressant on Trial* (Algonquin Books of Chapel Hill 2008)

Peter R. Breggin, M.D., *Psychiatric Drugs—Hazards to the Brain* (Springer Publishing Co., New York, 1983)

Peter R. Breggin, M.D., *Toxic Psychiatry—Why Therapy, Empathy and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry"* (St. Martin's Press 1991)

Peter R. Breggin, M.D., *Talking Back to Prozac* (St. Martin's Paperbacks 1994)

Peter R. Breggin, M.D., *Antidepressant Fact Book: What Your Doctor Won't Tell You About Prozac, Zoloft, Paxil, Celexa, and Luvox* (Perseus 2001) book review

Peter R. Breggin, M.D., and David Cohen, Ph.D., *Your Drug May Be Your Problem—How and Why to Stop Taking Psychiatric Medications* (Perseus 1999). I read this first 1999 edition. A "Fully Revised and Updated" edition was published in 2007 (by Da Capo/Perseus). book review

Peter R. Breggin, M.D., *Brain-Disabling Treatments in Psychiatry, Second Edition* (Springer Publishing Co. 2008)

Peter R. Breggin, M.D., *Psychiatric Drug Withdrawal—A Guide for Prescribers, Therapists, Patients, and Their Families* (Springer Publishing Co. 2013)

Vernon Coleman, M.B.Ch.B., D.Sc.(hon), *How to Stop Your Doctor Killing You* (European Medical Journal 2003), especially the chapter titled "Why Mental Health Care Isn't Always Worth Having".

Allen Frances, *Saving Normal—An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (Harper Collins 2013). I recommend this book despite my disagreement with the author about the validity of the concept of mental disorder and his belief that psychiatry has bona-fide treatment.

Joseph Glenmullen, M.D., *Prozac Backlash* (Simon & Schuster 2000)

Peter C. Gøtzsche, *Deadly Medicines and Organized Crime — How Big Pharma Has Corrupted Healthcare* (Radcliffe 2013), especially chapters 17 ("Psychiatry, the drug industry's paradise") and 18 ("Pushing children into suicide with happy pills")

Peter C. Gøtzsche, *Deadly Psychiatry and Organized Denial* (People'sPress 2015)

Stuart A. Kirk, et al., *Mad Science—Psychiatric Coercion, Diagnosis, and Drugs* (Transaction Publishers 2013)

Irving Kirsch, Ph.D., *The Emperor's New Drugs—Exploding the Antidepressant Myth* (Basic Books 2010)

Joanna Moncrieff, M.B.B.S., M.Sc., MRCPsych, M.D., *The Myth of the Chemical Cure—A Critique of Psychiatric Drug Treatment, Revised Edition* (Palgrave Macmillan 2009)

Joanna Moncrieff, M.B.B.S., M.Sc., MRCPsych, M.D., *A Straight Talking Introduction to Psychiatric Drugs* (PCCS Books 2009)

Joanna Moncrieff, M.B.B.S., M.Sc., MRCPsych, M.D., *The Bitterest Pills—The Troubling Story of Antipsychotic Drugs* (Palgrave MacMillan 2013)

Colin A. Ross, M.D., *The Great Psychiatry Scam—One Shrink's Personal Journey* (Manitou Communications, Inc., Richardson, Texas 2008).

Colin A. Ross, M.D., and Alvin Pam, Ph.D., *Pseudoscience in Biological Psychiatry* (John Wiley & Sons, Inc. 1995) book review

Elliot Valenstein, Ph.D., *Blaming the Brain—The Truth About Drugs and Mental Health* (Free Press 1998)

Robert Whitaker, *Mad in America* (Perseus 2002). In this book, the author documents that fact that people considered insane or mentally ill were more likely to recover and live good lives before the invention of modern biological psychiatry (psychiatric drugs, electroshock, and psychosurgery).

Robert Whitaker, *Anatomy of an Epidemic—Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (Crown Publishers 2010). In this sequel to *Mad in America*, Robert Whitaker reviews the evidence of harm caused by each class of psychiatric drugs and documents the increase in mental disability and illness caused by their use.

Articles

Ginger Ross Breggin, "On Being Human", empathictherapy.org

Dr. Peter Breggin, "New Research: Antidepressants Can Cause Long-Term Depression", Huffington Post (huffingtonpost.com), 11/16/2011

Monica Cassani, "How antidepressants (and benzos) ruined my life: Luke Montagu", July 18, 2015 — Beyond Meds: Alternatives to Psychiatry, http://beyondmeds.com

"High Anxiety", January 1993 *Consumer Reports* magazine

Siphiwe Sibeko, "Psychiatric Drugs Kill 500,000 Western adults annually, few positive benefits — leading scientist", rt.com, May 13, 2015; original article: "Does long term use of psychiatric drugs cause more harm than good?", *British Medical Journal*, 12 May 2015.

Julia Llewellyn Smith, "Lives 'left in ruin' by rising tide of depression drugs", *The Telegraph* (UK), 27 April 2014

Recommended Videos

"Psychiatric Drugs Are More Dangerous Than You Ever Imagined", YouTube.com and breggin.com. This is an excellent 9-minute video by Dr. Peter Breggin that should be seen by anyone and everyone taking, prescribing, or advocating the use of psychiatric drugs.

"Psychiatry causes harm, and it's widely denied...", YouTube.com. In this less than 2 minute video, Joanna Moncrieff, a psychiatrist and senior lecturer in Mental Health Sciences at the University College, London, summarizes the evidence showing psychiatric drugs harm people and that most of her fellow psychiatrists don't care.

A Psychiatrist's Perspective on Antidepressants (Kelly Brogan, M.D.), YouTube.com.

Dr. Peter Breggin testifying before U.S. House of Representatives Committee on Veterans' Affairs about newer (SSRI) antidepressants causing suicide; also available on YouTube.com.

"Generation Rx", by Kevin P. Miller, available on DVD from amazon.com and usually also on eBay.com, not to be confused with the A&E film by the same title. See amazon.com.

"The Drugging of Our Children", A Gary Null Production, garynull.com, available from amazon.com.

"NUMB: A Documentary, The Depressing Truth About Antidepressants". Watch this documentary before starting or stopping an SSRI antidepressant such as Paxil. This documentary illustrates the fact that psychiatric drugs such as SSRIs are often much easier to start than to stop and that even tapering off them slowly may be unsuccessful. The film ends with the film maker switching from Paxil to Prozac but being unable to stop taking SSRI "antidepressants" without intolerable withdrawal symptoms. See numbdocumentary.com.

"Psychiatric Drugs and Mass Shootings", YouTube.com. This video provides evidence psychiatric drugs cause violent behavior, contrary to the common view about mentally ill people needing to be "stabilized on meds" to prevent violence. I recommend this Citizens Commission on Human Rights (CCHR) video without endorsing CCHR itself nor the founder of CCHR, the Church of Scientology: See comment in *The Future of Anti-Psychiatry Activism*.

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antipsychiatry.org

The Case Against Psychotherapy

19–24 minutes

The best person to talk with about your problems in life usually is a good friend. It has been said, "Therapists are expensive friends." Likewise, friends are inexpensive "therapists". Contrary to popular belief, and contrary to propaganda by mental health professionals, the training of psychiatrists, psychologists, and other mental health professionals does little or nothing to make them better equipped as counselors or "therapists". It might seem logical for formal credentials like a Ph.D. in psychology or a psychiatrist's M.D. or D.O. degree or a social worker's M.S.W. degree to suggest a certain amount of competence on his or her part. The truth, however, is more often the opposite**:** In general, the less a person who is offering his or her services as a counselor has in the way of formal credentials, the more likely he or she is to be a good counselor, since such a counselor has only competence (not credentials) to stand on. Generally, the best person for you to talk with is a person who has worked himself or herself through the same problems you face in the nitty-gritty of life. You usually will benefit if you avoid the "professionals" who claim their value comes from their years of academic study or professional training.

When I asked a licensed social worker with a Master of Social Work (M.S.W.) degree who shortly before had been employed in a psychiatric hospital whether she thought the psychiatrists she worked with had any special insight into people or their problems her answer was a resounding *no*. I asked the same question of a judge who had extensive experience with psychiatrists in his courtroom,

and he gave me the same answer and made the point just as emphatically. Similarly, I sought an opinion from a high school teacher who worked as a counselor helping young people overcome addiction or habituation to pleasure drugs who both as a teacher and as a drug counselor had considerable experience with psychiatrists and people who consult them. I asked him if he felt psychiatrists have more understanding of human nature or human problems than himself or other people who are not mental health professionals. He thought a few moments and then replied, "No, as a matter of fact, I don't."

In his book *Against Therapy*, a critique of psychotherapy published in 1988, psychoanalyst Jeffrey Masson, Ph.D., speaks of what he calls "The myth of training" of psychotherapists. He says: "Therapists usually boast of their 'expertise,' the 'elaborate training' they have undergone. When discussing competence, one often hears phrases like 'he has been well trained,' or 'he has had specialized training.' People are rather vague about the nature of psychotherapy training, and therapists rarely encourage their patients to ask in any detail. They don't for a good reason: often their training is very modest. ... The most elaborate and lengthy training programs are the classic psychoanalytic ones, but this is not because of the amount of material that has to be covered. I spent eight years in my psychoanalytic training. In retrospect, I feel I could have learned the basic ideas in about eight hours of concentrated reading" (Atheneum/Macmillan Co., p. 248).

Sometimes even psychiatrists and psychologists themselves will admit they have no particular expertise. Some of these admissions have come from people I have known as friends who happened to be practicing psychologists. Illustrative are the remarks of one Ph.D. psychologist who told me how amazed members of his family were that people would pay him $50 an hour just to discuss their problems with him. He admitted it really didn't make any sense, since they could do the same thing with lots of other people for free. "Of course," he said, "I'm still going to go to my office tomorrow and collect $50 an hour for talking with people." Due to inflation, today the cost is usually higher than $50 per hour.

In his book *The Reign of Error*, published in 1984, psychiatrist Lee Coleman, M.D., says "psychiatrists have no valid scientific tools or expertise" (Beacon Press, p. ix).

Garth Wood, M.D., a British psychiatrist, included the following statements in his book *The Myth of Neurosis* published in 1986: "Popularly it is believed that psychiatrists have the ability to 'see into our minds,' to understand the workings of the psyche, and possibly even to predict our future behavior. In reality, of course, they possess no such skills. ... In truth there are very few illnesses in psychiatry, and even fewer successful treatments ... in the postulating of hypothetical psychological and biochemical causative processes, psychiatrists have tended to lay a smokescreen over the indubitable fact that in the real world it is not hard either to recognize or to treat the large majority of psychiatric illnesses. It would take the intelligent layman a long weekend to learn how to do it" (Harper & Row, 1986, p. 28-30; emphasis in original).

A cover article in *Time* magazine in 1979 titled "Psychiatry's Depression" made this observation: "Psychiatrists themselves acknowledge that their profession often smacks of modern alchemy - full of jargon, obfuscation and mystification, but precious little real knowledge" ("Psychiatry on the Couch", *Time* magazine, April 2, 1979, p. 74).

I once asked a social worker employed as a counselor for troubled adolescents whose background included individual and family counselling if she felt the training and education she

received as part of her M.S.W. degree made her more qualified to do her job than she would have been without it. She told me a part of her wanted to say yes, because after all, she had put a lot of time and effort into her education and training. She also mentioned a few minor benefits of having received the training. She concluded, however, "Most of the things I've done I think I could have done without the education."

Most mental health professionals however have an understandable emotional or mental block when it comes to admitting they have devoted, actually wasted, several years of their lives in graduate or professional education and are no more able to understand or help people than they were when they started. Many know it and won't, or will only rarely, admit it to others. Some cannot even admit it to themselves.

Hans J. Eysenck, Ph.D., is a psychology professor at the University of London. In the December 1988 issue of *Psychology Today* magazine, the magazine's senior editor described Dr. Eysenck as "one of the world's best-known and most respected psychologists" (p. 27). This highly regarded psychologist states this conclusion about psychotherapy: "I have argued in the past and quoted numerous experiments in support of these arguments, that there is little evidence for the practical efficacy of psychotherapy...the evidence on which these views are based is quite strong and is growing in strength every year" ("Learning Theory and Behavior Therapy", in *Behavior Therapy and the Neuroses,* Pergamon Press, 1960, p. 4). Dr. Eysenck said that in 1960. In 1983 he said this: "The effectiveness of psychotherapy has always been the specter at the wedding feast, where thousands of psychiatrists, psychoanalysts, clinical psychologists, social workers, and others celebrate the happy event and pay no heed to the need for evidence for the premature crystallization of their spurious orthodoxies" ("The Effectiveness of Psychotherapy: The Specter at the Feast", *The Behavioral and Brain Sciences* 6, p. 290).

In *The Emperor's New Clothes: The Naked Truth About the New Psychology*, (Crossway Books, 1985) William Kirk Kilpatrick, a professor of educational psychology at Boston College, argues that we have attributed expertise to psychologists that they do not possess.

In 1983 three psychology professors at Wesleyan University in Connecticut published an article in *The Behavioral and Brain Sciences*, a professional journal, titled "An analysis of psychotherapy versus placebo studies". The abstract of the article ends with these words: "...there is no evidence that the benefits of psychotherapy are greater than those of placebo treatment" (Leslie Prioleau, et al., Vol. 6, p. 275).

George R. Bach, Ph.D., a psychologist, and coauthor Ronald M. Deutsch, in their book *Pairing*, make this observation: "There are not enough therapists to listen even to a tiny fraction of these couples, and, besides, the therapy is not too successful. Popular impression to the contrary, when therapists, such as marriage counselors, hold meetings, one primary topic almost invariably is: why *is* their therapy effective in only a minority of cases?" (Peter H. Wyden, Inc., 1970, p. 9; emphasis in original).

In his book *What's Wrong With the Mental Health Movement*, K. Edward Renner, Ph.D., a professor in the Department of Psychology at the University of Illinois at Urbana, makes this observation in his chapter titled "Psychotherapy": "When control groups are included, those patients recover to the same extent as those patients receiving treatment. ...The enthusiastic belief expressed by therapists about their effectiveness, in spite of the negative results, illustrates the problem of the

therapist who must make important human decisions many times each day. He is in a very awkward position unless he *believes* in what he is doing" (Nelson-Hall Publishers, 1975, pp. 138-139; emphasis in original).

An example of this occurred at the psychiatric clinic at the Kaiser Foundation Hospital in Oakland, California. Of 150 persons who sought psychotherapy, all were placed in psychotherapy except for 23 who were placed on a waiting list. After six months, doctors checked on those placed on the waiting list to see how much better the people receiving psychotherapy were doing than those receiving none. Instead, the authors of the study found that "The therapy patients did not improve significantly more than did the waiting list controls" (Martin L. Gross, *The Psychological Society*, Random House, 1978, p. 18).

In the second edition of his book *Is Alcoholism Hereditary?*, published in 1988, Donald W. Goodwin, M.D., says "There is hardly any scientific evidence that psychotherapy for alcoholism or any other condition helps anyone" (Ballantine Books, 1988, p. 180).

British psychiatrist Garth Wood, M.D., criticizes modern day "psychotherapy" in his book *The Myth of Neurosis* published in 1986 with these words: "These misguided myth-makers have encouraged us to believe that the infinite mysteries of the mind are as amenable to their professed expertise as plumbing or an automobile engine. This is rubbish. In fact these talk therapists, practitioners of cosmetic psychiatry, have no relevant training or skills in the art of living life. It is remarkable that they have fooled us for so long. ... Cowed by their status as men of science, deferring to their academic titles, bewitched by the initials after their names, we, the gullible, lap up their pretentious nonsense as if it were the gospel truth. We must learn to recognize them for what they are - possessors of no special knowledge of the human psyche, who have, nonetheless, chosen to earn their living from the dissemination of the myth that they do indeed know how the mind works" (pp. 2-3).

The superiority of conversation with friends over professional psychotherapy is illustrated in the remarks of a woman interviewed by Barbara Gordon in a book published in 1988: "For Francesca, psychotherapy was a mixed blessing. 'It helps, but not nearly as much as a few intense, good friends,' she said. '...I pay a therapist to listen to me, and at the end of forty-five minutes he says, 'That's all the time we have; we'll continue next week.' A friend, on the other hand, you can call any hour and say, 'I need to talk to you.' They're there, and they really love you and want to help." In an interview with another woman on the same page of the same book, Ms. Gordon was told this, referring to pain from losing a husband: "Good shrinks can probably deal with it; the two I went to didn't help" (Barbara Gordon, *Jennifer Fever*, Harper & Row, 1988, p. 132).

The June 1986 issue of *Science 86* magazine included an article by Bernie Zilbergeld, a psychologist, suggesting that "we're hooked on therapy when talking to a friend might do as well." He cited a Vanderbilt University study that compared professional "psychotherapy" with discussing one's problems with interested but untrained persons: "Young men with garden variety neuroses were assigned to one of two groups of therapists. The first consisted of the best professional psychotherapists in the area, with an average 23 years of experience; the second group was made up of college professors with reputations of being good people to talk to but with no training in psychotherapy. Therapists and professors saw their clients for no more than 25 hours. The results: "Patients undergoing psychotherapy with college professors showed ... quantitatively as much improvement as patients treated by experienced professional psychotherapists" (p. 48). Zilbergeld

pointed out that "the Vanderbilt study mentioned earlier is far from the only one debunking the claims of professional superiority" (ibid, p. 50).

Martin L. Gross, a member of the faculty of The New School For Social Research and an Adjunct Assistant Professor of Social History at New York University, has argued that "the concept that a man who is trained in medicine or a Ph.D. in psychology has a special insight into human nature is false" (quoted in "And ACLU Chimes In: Psychiatric Treatment May Be Valueless", *Behavior Today*, June 12, 1978, p. 3).

Implicit in the idea of "psychotherapy" is the belief that "psychotherapists" have special skills and special knowledge that are not possessed by other people. In making this argument against "psychotherapy", I am arguing only that conversation with psychotherapists is no better than conversation with other people. In his defense of psychotherapy in a book published in 1986, psychiatrist E. Fuller Torrey makes this argument: "Saying that psychotherapy does not work is like saying that prostitution does not work; those enjoying the benefits of these personal transactions will continue doing so, regardless of what the experts and researchers have to say" *(Witchdoctors and Psychiatrists: The Common Roots of Psychotherapy and Its Future*, Jason Aronson, Inc., p. 198). If you really are desperate for someone to talk to, then "psychotherapy" may in fact be enjoyable. However, if you have a good network of friends or family who will talk to you confidentially and with your best interests at heart, there is no need for "psychotherapy". Just as a happily married man or a man with a good sexually intimate relationship with a steady girlfriend is unlikely to have reason to hire a prostitute, people with good friendships with other people are unlikely to need "psychotherapy".

What if you need information about how to solve a problem your family and friends can't help you with? In that case usually the best person for you to talk to is someone who has lived through or is living through the same problem you face. Sometimes a good way to find such people is attending meetings of a group organized to deal with the kind of problem you have. Examples (alphabetically) are Alcoholics Anonymous, Alzheimer's Support groups, Agoraphobia Self-Help groups, Al-Anon (for relatives of alcoholics), Amputee Support groups, Anorexia/Bulimia support groups, The Aphasia Group, Arthritics Caring Together, Children of Alcoholics, Coping With Cancer, Debtors Anonymous, divorce adjustment groups, father's rights associations (for divorced men), Gamblers Anonymous, herpes support and social groups such as HELP, Mothers Without Custody, Nar-Anon (for relatives of narcotics abusers), Narcotics Anonymous, Overeaters Anonymous, Parents Anonymous, Parents in Shared Custodies, Parents Without Partners, Potsmokers Anonymous, Resolve, Inc., (a support group that deals with the problems of infertility and miscarriage), Shopaholics Ltd., singles groups, Smokers Anonymous, The Stuttering Support Group, women's groups, and unwed mothers assistance organizations. Local newspapers often have listings of meetings of such organizations. Someone who is a comrade with problems similar to yours and who has accordingly spent much of his or her life trying to find solutions for those problems is far more likely to know the best way for you to deal with your situation than a "professional" who supposedly is an expert at solving all kinds of problems for all kinds of people. The myth of professional psychotherapy training and skill is so widespread, however, that you may find people you meet in self-help groups will recommend or refer you to a particular psychiatrist, psychologist, or social worker. If you hear this, remember what you read (above) in this pamphlet and disregard these recommendations and referrals and get whatever counselling you need from nonprofessional people in the group who have direct experience in their own lives with the kind

of problem that troubles you. You will probably get better advice and - importantly - you will avoid psychiatric stigma.

In their book *A New Guide To Rational Living*, Albert Ellis, Ph.D., a New York City psychologist, and Robert A. Harper, Ph.D., say they follow "an educational rather than a psychodynamic or a medical model of psychotherapy" (Wilshire Book Co., 1975, p. 219). In his book *Get Ready, Get Set...Prepare to Make Psychotherapy A Successful Experience For You*, psychotherapist and psychology professor Harvey L. Saxton, Ph.D., writes: "What is psychotherapy? Psychotherapy is simply a matter of reeducation. Reeducation implies letting go of the outmoded and learning the new and workable. Patients, in one sense, are like students; they need the capacity and willingness to engage in the process of relearning" (University Press of America, 1993, p. 1). In their book *When Talk Is Not Cheap, Or How To Find the Right Therapist When You Don't Know Where To Begin*, psychotherapist Mandy Aftel, M.A., and Professor Robin Lakoff, Ph.D., say "Therapy...is a form of education" (Warner Books, 1985, p. 29). Since so-called psychotherapy is a form of education, not therapy, you need not a doctor or therapist but a person who is qualified to educate in the area of living in which you are having difficulty. The place to look for someone to talk to is where you are likely to find someone who has this knowledge. Someone whose claim to expertise is a "professional" psychotherapy training program rarely if ever is the person who can best advise you.

THE AUTHOR, Lawrence Stevens, is a lawyer whose practice has included representing psychiatric "patients". His pamphlets are not copyrighted. You are invited to make copies for distribution to those who you think will benefit.

2001 UPDATE

"In my training [as a clinical psychologist] I heard lots about 'biochemical imbalances' and "faulty cognitions," but I can't recall ever hearing about 'loss of morale' or 'spiritual crisis.' From my experience with depression, it is always a psychological, social, and spiritual event, and providing morale for someone at a crossroads in his or her life is perhaps the most important thing one human being can do for another. ... You can look for a talented morale builder among psychiatrists, psychologists, and social workers, but your chance of finding one will be better if you look almost anywhere else. [p. 63] ... If you need help, forget about professional credentials and associate with those who energize you and help you laugh. [pp. 65-66] ... There is no unequivocal evidence that professionally trained therapists and teachers are superior helpers to so-called untrained laypeople. ... research shows that nonprofessionals can be as successful as professionals in helping even those with the most severe problems in living. [p. 286] ... Authenticity has been selected and socialized out of institutional helpers. [p. 287]" Bruce Levine, Ph.D., *Commonsense Rebellion: Debunking Psychiatry, Confronting Society* (Continuum, New York, 2001).

Notes on
PSYCHIATRIC FASCISM

by Don Weitz
Toronto, Ontario

For almost 150 years, psychiatry has been masquerading as a medical science and as a branch of medicine. It is not and never was a science or a type of health care. Modern psychiatry is driven by unproved empirical assumptions, medical biases, and pseudo-scientific opinions. There are no scientifically established, independently proven facts in psychiatry. Psychiatry, in fact, has no laws or testable hypotheses and no coherent and comprehensive theory. Psychiatry conspicuously lacks scientific proof or evidence to support its news-media-parroted claims of "mental illness" or "disorders".

After about seventy years of psychiatric practices and research, there is still no diagnostic test for schizophrenia or any of the other three hundred so-called mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is essentially a list of class-driven moral judgements of allegedly abnormal behaviour, published and propagandized by the American Psychiatric Association. The DSM is the official bible of organized psychiatry. The DSM is the equivalent of the *Malleus Maleficarum* in the middle ages, which Spanish inquisitors used to identify, target, stigmatize and burn witches and heretics. Today's witches, heretics, and scapegoats are labeled mentally ill or schizophrenic.

Hospital psychiatry with its emphasis on the control of inmate behaviour through high risk behaviour modification programs, biological "treatments", physical and mechanical restraints, locked doors and wards, and seclusion/isolation rooms, have always exhibited several fascist elements. I want to focus on three: **fear, force** and **fraud**. These are the guiding principles and policies used to control citizens and groups in the population whom government leaders and other authorities, including the police and so-called mental health experts, have judged to be dissident, problematic or difficult to control. Hospital psychiatry is very similar to the prison system. In the prison or correctional system psychiatrists have been used as consultants to design dangerous, unethical behaviour modification programs and to conduct high risk drug experiments on prisoners. Both the psychiatric system and the prison system systematically use fear, force and fraud for the purpose of social control and punishment - not for purposes of treatment or rehabilitation, both of which are euphemisms. It is or should be obvious that *forced treatment is in fact punishment*. It is frequently cruel and usual and should therefore be banned in the United States under that nation's Eighth constitutional amendment. Virtually all treatments in psychiatric facilities are forced or administered without informed consent. They are administered against the "patient's" (the *prisoner's*) will or with consent obtained by threatening the "patient" with worse consequences, or with consent obtained by keeping the "patient" unaware of important information about serious risks and alternatives. Informed consent in psychiatry is a cruel sham. It doesn't exist.

Fear/Terror - "Terror acts powerfully upon the body through the medium of the mind and should be employed in the cure of madness. Fear accompanied with pain and the sense of shame has sometimes cured the disease". That was written almost two centuries ago in 1818 by Dr. Benjamin Rush, father of American psychiatry, and the first president of the APA, whose face still appears on the official seal of the American Psychiatric Association. Dr. Rush advocated and practiced terror by designing and using the straitjacket, the tranquilizer chair and "fear of death" on numerous inmates in 19th century lunatic asylums. Rush once had his son locked up in an insane asylum - some father!

Fear is a powerful motivator in enforcing conformity, obedience and making people submit to authority. Historically, inducing and manipulating fear or masked terror has always been a key policy and practice in all fascist regimes, such as Italy under Mussolini, Nazi Germany under Hitler, and the Soviet Union under Stalin - in fact, under any dictatorship. The threat of punishment, torture and the threat of being killed is enough to cause fear, panic, and terror if most of us. We do as we're told *or else*.

As used in psychiatry, fear or terror is more selective but is widespread and powerful. In the institution, psychiatry frequently resorts to blackmail to control the more "uncontrollable" and difficult or non-compliant patient. Psychiatrists and other therapists threaten their patients with longer incarceration, higher doses of forced neuroleptics or "antidepressants", and/or threatened transfers to more severe maximum security institutions if they misbehave, fail to follow doctors' orders, refuse to take their "medication", refuse to follow institutional rules, or annoy their captors in other ways. Generally aimed at captive populations of involuntary patients, these threats typically strike fear in many of them, and psychiatrists know it. For example, some years ago, several patients and former patients of Queen Street Mental Health Centre, Toronto's notorious mental hospital or psycho-prison, told me and other activist-critics that psychiatrists have threatened, if they didn't calm down or control themselves, to transfer them to Penetang, the Oakridge division of Penetanguishene Mental Health Centre, a maximum security behaviour modification facility in Ontario, known for its harsh and brutal environment. Penetang was and still is recognized as punishment, one of the most barbaric psycho-prisons in Canada. It should have been shut down years ago, especially after a scathing report about many of its abuses by psychiatrist Steven Harper.

Threatening patients with physical restraints or solitary confinement is also extremely effective in arousing fear or panic in patients. On virtually every psychiatric ward or unit, there is a place, euphemistically called "The Quiet Room", a barren and forbidden cell-like room, with a mattress or sink, usually no toilet or blankets. While languishing the quiet room, patients are sometimes further restrained by leather cuffs, two-point and four-point restraints, tightly wrapped around their wrists and/or ankles so they can barely move, for hours at a time. The mere threat of loss of freedom, involuntary committal, or being locked up in a psychiatric ward or institution against your will, and without any trial or public hearing, is enough to frighten most of us. In virtually every province and territory in Canada, these are the main criteria or reasons for being locked up or committed to a psychiatric institution**:** judgement of mental illness or disorder; judgement of threatening to physically hurt yourself or another person; judgement of being unable to look after yourself. Note that these criteria are subjective moral judgements of dissident behaviour based on observation and opinion, not medical or scientific facts. Despite the fact that mental illness or mental disorder, which in my opinion is a metaphor for dissidence, has

never been officially classified as a medical disease or illness, only physicians are legally authorized to make these non-medical and fateful judgements.

In Ontario, any doctor can sign a committal form which forces an individual to be locked up in any psychiatric facility for the first 72 hours for observation and assessment. Two other doctors can sign a form authorizing an individual's imprisonment for another 2-4 weeks. During the last few years, approximately 50% of thousands of people treated in Ontario's nine psychiatric hospitals were involuntarily committed.

The threat or fact of losing your freedom being locked up in a psychiatric facility for days or months at a time is terrifying. The minimal or non-existent advocacy currently provided in Ontario makes the right to appeal or protest a sham, and this serves to heighten people's fear and despair. The mere *threat* of forced psychiatric treatment as well as the treatment itself can be terrorizing - e.g., electroshock, also called electro-convulsive therapy (ECT), but more accurately called electro-convulsive brainwashing by shock survivor critics such as Leonard Frank. My close friend Mel told me of being dragged by several aids along the hallway to a hospital shockroom. I can imagine his terror and the terror of others who suffered the same fate. I suffered a similar terror when I was forcibly subjected to over 50 subcoma insulin shocks in the 1950s. To the surprise of many people, this barbaric brain-damaging and memory destroying treatment not only exists, but is expanding in Canada and the United States. Its main targets are women and the elderly, particularly elderly women.

There is also the threat of psychiatric drugs, euphemistically called "medication". These chemicals such as minor tranquilizers, antidepressants and the anti-psychotics such as Haldol, Modicate, Thorazine, and the so-called mood modifier Lithium, are not natural substances but are manufactured poisons, aptly called neurotoxins by psychiatrist and psychiatry critic Peter Breggin in several of his books and Joseph Glenmullen, a clinical instructor in psychiatry at Harvard Medical School, in his book *Prozac Backlash*. These chemicals have no scientifically proven medical value or benefit. What they do is control or subdue any problematic or disturbing behaviour, mood and emotion. These toxins, particularly neuroleptics like Haldol, Modicate, Chlorpromazine, are so disabling, powerful and fearsome that many psychiatric survivors and other critics call them chemical lobotomies or chemical straitjackets. These drugs have many serious and disabling effects, called "side effects" to minimize how they are perceived, such as trembling, uncontrollable shaking or movement of the hands or other parts of the body (which occur in the neurological disorder such as Parkinsonism or tardive dyskenisia), powerful muscular cramps, blurred vision, restless pacing, nightmares, sudden outbursts of anger, agitation, memory loss, fainting, blood disorders, seizures, and sudden death. These so-called side effects are the drugs' *intended* effects. This fear of psychiatric drugs is compounded by ignorance and uncertainty, because psychiatrists and other doctors fail to inform patients of the drugs' horrific effects.

Without the use or threat of force, fascism could not exist. Machiavelli, Mussolini, Hitler knew this. All dictators, would-be dictators, and bullies know this basic fact. And this is the case with psychiatry. Without the use and threat of force, institutional psychiatry would die. Lots of psychiatrists would be out of a job. I wish that would happen! Psychiatry gets its authority and power to force, imprison, involuntarily commit, and treat individuals against their will from the state.

Mental health legislation gives psychiatrists and other physicians the power to involuntarily commit any person they "believe", after only minutes of examination, to be dangerous to themselves or others. This is problematic. The Mental Health Act wrongly assumes that doctors can predict dangerous and violent behaviour, which they cannot do. It is worth emphasizing that Ontario's Mental Health Act, as with other mental health acts across Canada and the United States, legally sanction the state to use force to detain or imprison people for days, weeks or months at a time. Unfortunately, there has never been a public outcry or protest over the fact that people judged or assumed to be crazy or dangerous, but not charged with any crime, can nevertheless be locked up without a trial or the legal rights accorded to people charged with crimes such as murder or rape. This is *prevention detention*, which is illegal in Canada and other so-called democratic countries, but it is legal and a common practice in all police states and totalitarian countries. I know of no lawsuit challenge to involuntary committal as *preventive detention* and therefore as unconstitutional.

In institutional psychiatry in fascist states, forced treatment is the rule, not the exception. Forced treatment and tortuous terminal medical experiments inflicted on thousands of Jews, gypsies, political prisoners, women and children, were carried out in death camps during World War II throughout Nazi Germany. There is now irrefutable, documentary evidence that it was the German psychiatrists, particularly prominent professors of psychiatry, and psychiatry department heads, who were chiefly responsible for initiating and administering the infamous T4 program, which involved the mass murder of over 200,000 mental patients and thousands of sick and disabled children and adults during the holocaust. The term euthanasia and mercy death to describe this murderous program is a cruel euphemism.

Much of biological psychiatry, which is largely based on unproved assumptions about the biological and genetic causes of schizophrenia and other mental disorders, can be traced back to the racist, eugenics-driven psychiatrist in Nazi Germany, Ernst Rudin, who propagated the myth that schizophrenia is a genetic disease. He, along with hundreds of other psychiatrists in the T4 program of mass murder of psychiatric patients, is still cited in some psychiatric journal articles, as documented by researcher-activist Lenny Lapon in his brilliant book, *Mass Murderers in White Coats: Psychiatric Genocide in Nazi Germany*. He states that several German psychiatrists from the Nazi era emigrated to the United States and Canada and succeeded in indoctrinating many of his colleagues in his biological, genetic and racist theories of mental illness. Heinz Layman who emigrated to Canada in 1937, is chiefly responsible for introducing Thorazine or Chlorpromazine, and propagated the use of psychiatric drugs in Canada.

We now have an epidemic of brain damage caused by psychiatric drugs, partly due to Layman and all the other doctors he taught. In one 1954 journal article, Layman admitted that Thorazine was a "pharmacological substitute for lobotomy". Despite publicly acknowledging this alarming fact, it never stopped Layman from using it on many "schizophrenic" patients in Montreal's Douglas Hospital. Layman also persuaded Ewen Cameron to administer chlorpromazine and many other drugs and massive amounts of electroshock. Chlorpromazine, considered an experimental drug at the time, was widely used on many patients during Cameron's infamous brainwashing experiments at the Allan Memorial Institute in the 1950s and 1960s.

There was no informed consent then, and there is none now. During the Nazi years, the doctors didn't seek permission. According to Nazi ideology, these were "useless eaters", "subhumans". This is a mindset that still rules in biological psychiatry throughout North America. Another legacy of psychiatry in Nazi Germany is the widespread acceptance and justification of abuse to break the will of non-compliant or rebellious patients. Physical or mechanical restraints such as straps, ropes, belts, handcuffs and solitary confinement are used in psychiatric institutions not to treat or protect but to punish people for dissident or rebellious behaviour. It is this naked display of force and threats against patients by hospital staff which resembles the awesome brutality of German psychiatric staff during the holocaust.

Fraud: A very apt quote by Leonard Roy Frank, author of *Influencing Minds* is "Mystification is psychiatry's defense against the danger of being found out". Many of the labels or diagnoses used by psychiatrists do not refer to real psychiatric problems or to actual illnesses. Psychiatry professor Thomas Szasz has exposed the fraud and the myth of the concept of mental illness in many books, starting with his classic *The Myth of Mental Illness*. This misrepresentation one of the greatest scientific scandals in our scientific age. The code words that are now used in biological psychiatry such as *anti-depressants* do not assist people with overcoming depression or get at the causes of depression. The term "Quiet Room" is a fraudulent code for solitary confinement. The word "medication" is also a misleading euphemism and misrepresentation for *toxic substances* to which many of us have been subjected.

I've tried to show that institutional, coercive psychiatry has a fascist history and that biological psychiatry as practiced today in psychiatric facilities in Canada and the United States is still based on fear, force and fraud. Psychiatry does not deserve public or government support. We must work to abolish psychiatry. We must also continue working to create self-help advocacy groups, more drop-in centers, and more affordable, supportive housing in our communities. We need to create our own alternatives to the monstrous and evil mental health system. By doing this, we empower ourselves. This is our work, our challenge, and our hope.

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25 Reasons Psychiatry Must Be Abolished

7–9 minutes

by Don Weitz

1. Because psychiatrists frequently cause harm, permanent disabilities, death - death of the body-mind-spirit.

2. Because psychiatrists frequently violate the Hippocratic Oath which orders all physicians "First Do No Harm."

3. Because psychiatrists patronize and disempower people, especially their patients.

4. Because psychiatry is not a medical science.

5. Because psychiatry is quackery, a pseudo-science which lacks independent diagnostic tests, testable hypotheses, and cures for "schizophrenia" and all other types of alleged "mental illness" or "mental disorder".

6. Because psychiatrists can not accurately and reliably predict dangerousness, violence, or any other type of human behaviour, yet make such claims as "expert witnesses", and with the media promote the "dangerous mental patient" myth/stereotype.

7. Because psychiatrists have caused a worldwide epidemic of brain damage by promoting and prescribing brain-disabling treatments such as the neuroleptics, antidepressants, electroconvulsive brainwashing (electroshock), and psychosurgery (lobotomy).

8. Because psychiatrists manufacture hundreds of "mental disorders" classified in its bible called "Diagnostic and Statistical Manual of Mental Disorders" (a modern witch-hunting manual); such "mental disorders" and "symptoms" are in fact negative, class-and-culturally-biased moral judgments for dissident ways of coping with personal problems and alternative ways of perceiving, interpreting or being in the world.

9. Because psychiatrists, blinded by their medical model bias, fraudulently pathologize and label people's serious life or existential crises as "symptoms" of "mental illness" or "mental disorder" such as "schizophrenia","bipolar affective disorder", and "personality disorder".

10. Because psychiatrists compound this fraud by falsely claiming, without scientific proof, that these "mental disorders" are caused by a "biochemical imbalance" in the brain, genetic factors or "genetic predispositions", despite the fact that there are no genetic factors in "mental illness".

11. Because psychiatrists frequently misinform their patients, families and the public by claiming that brain-disabling procedures such as the neurotoxins (e.g.,"antipsychotic medication" and "antidepressasnts"), electroconvulsive brainwashing (electroconvulsive therapy/"ECT"), psychosurgery (lobotomy) and other behaviour modification-mind control procedures are "safe, effective and lifesaving". The exact opposite is tragically true.

12. Because psychiatrists routinely deceive or lie to patients, prisoners, their families, and the public.

13. Because psychiatrists routinely and willfully violate the medical-ethical principle of "informed consent" by misinforming or not informing their patients about the numerous toxic, disabling and frequently permanent effects of the neuroleptics such as memory loss, tardive dyskinesia, tardive psychosis, parkinsonism, dementia (all signs of brain damage), and death.

14. Because psychiatrists routinely threaten, intimidate or coerce many patients - particularly women, children, the elderly, and prisoners - into consenting to health-threatening/brain-damaging "treatment" such as the antidepressants, neuroleptics, electroconvulsive brainwashing, and hi-risk experiments.

15. Because psychiatrists frequently fail to fully inform psychiatric inmates and prisoners about existing safe and humane, non-medical alternatives in the community such as survivor-controlled crisis centres, drop-ins, self-help or advocacy groups, diet, massage, wholistic medicine, affordable supportive housing, and jobs.

16. Because psychiatrists are sexist in frequently stereotyping women in crisis as "hysterical" or "over-emotional", blaming women whenever they voice real complaints and assertively express their feelings and emotions, prescribing massive doses of tranquilizers and antidrepressants to disproportionately large numbers of women, and in sexually assaulting women in their offices and institutions.

17. Because psychiatrists, particularly white male psychiatrists, are homophobic - the American Psychiatric Association (APA) once labelled homosexuality as a "mental illness" or "mental disorder" - and have used forced electroshock on lesbians, trying to coerce them into adopting a heterosexual life style.

18. Because psychiatrists are ageist in prescribing tranquilizers, antidepressants ("medication") and electroconvulsive brainwashing for disproportionately large numbers of elderly people - a form of elder abuse.

19. Because psychiatrists are racist in disproportionately incarcerating and drugging people of African descent, aboringal people, other people of colour and labelling them "psychotic" or "schizophrenic".

20. Because psychiatrists routinely violate people's civil rights, human rights and constitutional rights such as imprisoning innocent people without court trial or public hearing ("involuntary commitment"), and subjecting them to cruel and unusual punishments or tortures such as forced drugging, electroconvulsive brainwashing, psychosurgery, solitary confinement, "chemical restraints", and 4-point or 5-point restraints.

21. Because psychiatrists masterminded the mass murder of hundreds of thousands of vulnerable people including disabled children, the elderly and psychiatric patients during The Holocaust in Nazi Germany, and "selected" hundreds of thousands of concentration camp prisoners for death ("T-4 euthanasia" program) - historical facts still missing in psychiatric textbooks and histories.

22. Because psychiatrists have willingly participated in and administered mind-control experiments in the United States and Canada since the early 1950s - its chief targets have been poor patients, women, dissidents and prisoners.

23. Because psychiatry, particularly institutional-biological psychiatry, is based on the 3 Fs**:** Fear, Fraud,and Force.

24. Because psychiatry is a form of social control or punishment - not treatment.

25. Because psychiatry, particularly institutional-biological psychiatry, is fascist - a direct threat to democracy, human rights and life.

A note from the author: This statement is a slightly revised version of the original written in Spring 1998. Feel free to add and publish your own reasons. I am a psychiatric survivor and antipsychiatry activist who has been involved in the psychiatric survivor liberation movment for 24 years. I am also co-editor of "Shrink Resistant: The Struggle Against Psychiatry in Canada" (1988), host-producer of the antipsychiatry program "Shrinkrap" on CKLN radio (88.1 FM) in Toronto, member of People Against Coercive Treatment (P.A.C.T.), and member of the Ontario Coalition Against Poverty (OCAP).]

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